

# Foreword

The Survey Assessment of Vietnamese Youth (SAVY) undertaken in late 2003 was a collaboration of the Ministry of Health, General Statistics Office with technical and financial support from the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF).

This is the first nationwide baseline survey of youth ever undertaken in Viet Nam. It mainly aims to collect data on various aspects of youth life in order to inform policy and programmes in the adolescent and youth health and development area.

SAVY reveals a positive picture of Vietnamese youth as they face both challenges and opportunities in a changing economic and social environment. Compared with young people in other Asian countries, Vietnamese youth display relatively less risky behaviour, are supported by protective factors and are optimistic and eager to build a prosperous country. However, this survey does reveal that some young people will encounter considerable challenges in their transition to adulthood, unless provided with support. It is important that parents, the community and the government, with the support of international agencies and young people, work together to ensure the healthy development of young people in Viet Nam.

## **The main report includes two parts:**

**Part I** Introduction and Methodology Chapters

**Part II** Eleven thematic results and one Recommendations Chapter

We acknowledge the valuable contribution made by national and international experts including those in the Experts' group, the Executive Committee, the Scientific Committee, professionals from the Ministry of Health, General Statistics Office, WHO, UNICEF, East-West Center in Hawaii, Johns Hopkins University... as well as the Central Youth Union, Viet Nam Women's Union, People's Committee of all levels, interviewers from local statistics offices and especially youth and their parents from 42 provinces across the country.

We are very delighted to introduce this report to all policy makers, managers, scientists, researchers, national and international organizations who are interested in adolescent and youth health and development in Viet Nam.

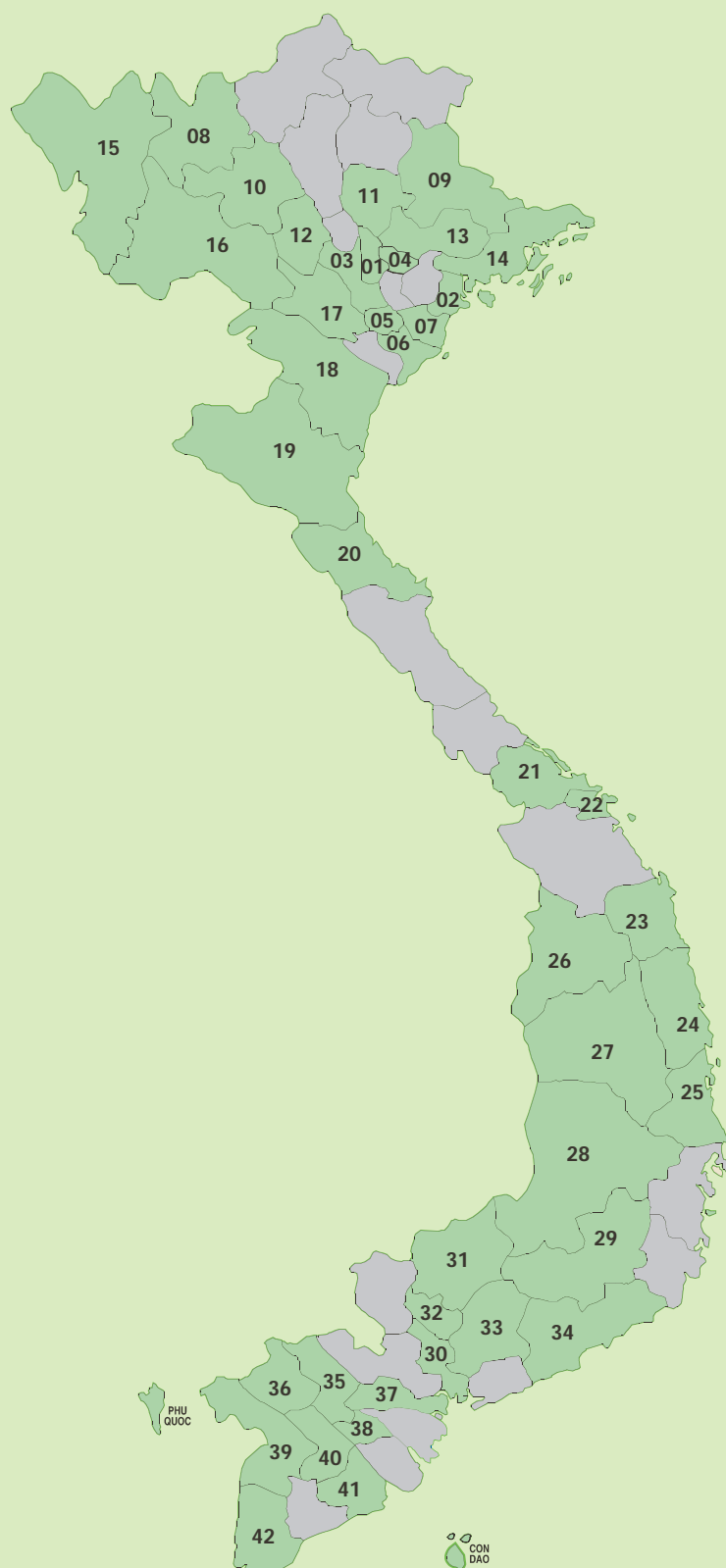
On behalf of SAVY Executive Committee

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## MAP OF PROVINCES & CITIES WHERE SAVY WAS CONDUCTED



### 1. Red River Delta

- 01 Ha Noi
- 02 Hai Phong
- 03 Ha Tay
- 04 Bac Ninh
- 05 Ha Nam
- 06 Nam Dinh
- 07 Thai Binh

### 2. North East

- 08 Lao Cai
- 09 Lang Son
- 10 Yen Bai
- 11 Thai Nguyen
- 12 Phu Tho
- 13 Bac Giang
- 14 Quang Ninh

### 3. North West

- 15 Lai Chau
- 16 Son La
- 17 Hoa Binh

### 4. North Central

- 18 Thanh Hoa
- 19 Nghe An
- 20 Ha Tinh
- 21 Thua Thien Hue

### 5. South Central

- 22 Da Nang City
- 23 Quang Ngai
- 24 Binh Dinh
- 25 Phu Yen

### 6. Central Highlands

- 26 Kon Tum
- 27 Gia Lai
- 28 Dac Lak
- 29 Lam Dong

### 7. South East

- 30 Ho Chi Minh City
- 31 Binh Phuoc
- 32 Binh Duong
- 33 Dong Nai
- 34 Binh Thuan

### 8. Mekong River Delta

- 35 Dong Thap
- 36 An Giang
- 37 Tien Giang
- 38 Vinh Long
- 39 Kien Giang
- 40 Can Tho
- 41 Soc Trang
- 42 Ca Mau

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# Executive Summary

## Introduction

The Survey Assessment of Vietnamese Youth (SAVY) is the largest and most comprehensive survey of youth ever undertaken in Viet Nam. A collaboration of the Ministry of Health, General Statistics Office, the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF), the survey involved 7,584 youth aged 14 to 25 years from 42 provinces across the country, from the smallest rural hamlet to the largest cities. Using a household sample, youth were invited to a central location to complete both a face-to-face interview and a self-administered anonymous survey which contained sensitive questions young people could answer in private. What results is the most extensive understanding of the social life, attitudes and aspirations of young Vietnamese people today.

SAVY indicates that Vietnamese youth face many challenges in negotiating the changing economic and social climate. At particular risk are vulnerable young people, notably those from ethnic minority backgrounds and in remote areas where poverty acts as a barrier to education and employment. However, SAVY indicates that young Vietnamese people have a very strong support network through friends, family and the community, which will help to protect and support them through these challenges.

## Young People as Part of Vietnamese Families

Young people in Viet Nam have a very strong sense of connection with their families. Family structure is such that, because of lower mortality rates and the rarity of divorce, families are generally intact. Even amongst young married people the trend is still to live with the husband's family. Young people participate fully in family life, are listened to and feel valuable to their family. Family is a protective factor for young people, even though a small but significant percentage reported some family conflict.

It is important to note here the marked differences between urban and rural households. Predictably

rural families are larger and more complex but have fewer resources to share around. They have higher rates of young marriage and of pregnancy. School drop-out rates are high, and attendance and literacy levels are lower in rural areas, particularly among ethnic minorities. Rural youth work in unskilled jobs and have less access to information sources, and therefore less knowledge of reproductive health issues. SAVY data indicates strongly the need for support to these areas.

## Education

Education data is encouraging, showing that school attendance and literacy levels are high, and attitudes to schooling and teachers are very positive. School environments have become more supportive of young people, particularly young women, in recent years, with students having an opportunity to 'have a say' at school and teachers praising students when they do well. Few students reported a heavy workload, which is a surprising finding. Interesting in this sense however is the very high percentage of private tutoring that takes place outside of school hours. The main reason for not attending school or for dropping out is still because families "can't afford school fees or expenses". This is of course an influence on the fact that the highest education level attained by the majority of respondents is lower secondary school level. It is alarming in this respect that SAVY data indicates that young people may lose their literacy skills after leaving school. Extremely high numbers of young people report that they had wanted or did want to go to university, in stark contrast to the actual numbers that can.

## Work and Employment

Young people identified work and increased opportunities to work as the highest priority in terms of their future aspirations. However, across all groups, it was consistently reported that it was difficult to find a job, though just over half of all young people surveyed have worked for pay at some time, with fairly high levels of satisfaction. In the context of the importance of work, it is discouraging to find that only a relatively small percentage of respondents have been involved in some form of job training.



## Friendships, Dating, Sexuality and Reproductive Health

Traditional attitudes and practices towards relationships are the norm in Viet Nam, where premarital sex is still considered improper, friendships with young people of the same sex is the usual practice and there is very little acceptance of homosexuality. Within intimate relationships, kissing, touching private parts and sexual intercourse are not common. When it does take place, the decision to have sex appears to be well-considered and often occurs within an already committed relationship and in environments that are safe. This pattern of sexual activity within a committed relationship signals the continuance of strong moral values about love.

Of relevance is that about one third of single urban young males and one quarter of single rural young men 22-25 reported premarital sex although very few single young women did. The majority of respondents were generally not accepting of the practice of premarital sex, however, married women reported a much higher rate of sex before marriage. Many SAVY findings indicate different gender expectations relating to premarital sexual practices of young men and young women.

Although young people believe in the practical effectiveness of condoms, their attitudes to condom

use were generally negative, associating them with indecent relations including sex work. Contraception is used by many married couples however it is used irregularly by single people. Two thirds of young women still have limited knowledge of the fertile time in the menstrual cycle. Generally sex work was viewed negatively however, young people do have an understanding and tolerance of some of the complex factors that result in people's involvement in sex work. High rates of condom use was reported by young men having sex with sex workers.

## Pregnancy and Abortion Experiences

The experience of pregnancy and abortion is concentrated in married women and the data indicates that there is still a stigma associated with unmarried pregnant women. In terms of health care during pregnancy, a very high percentage reported having had a check up during their first pregnancy. Consistently, access to services and use of public health centers are much lower amongst ethnic minority young women.

Abortion services were reported to be used by both married and unmarried women but compared with other surveys, the rates for abortion reported in SAVY seems low. Clearly abortion is stigmatized, particularly for unmarried young women.

## Awareness, Knowledge and Sources of Reproductive Health Information

Extensive information campaigns and access to a wide variety of information sources means that, generally, young people in Viet Nam are well-informed about reproductive health, particularly contraception but less so about Sexually Transmitted Infections (STIs). However, accuracy of knowledge is not generally of a high standard.

Mass media, particularly television, is the most common information source on reproductive health. Professionals were the next highest category, and younger respondents still in school were most likely to receive their information from teachers. The oldest group, 22-25 relied on their peers for information. Young women accessed the family, particularly their parents, as a source of information much more than young men. It is encouraging that the data indicates that the youngest girls 14-17 talk more about their experiences of puberty compared with older girls, suggesting an increased awareness and openness to discuss previously hidden issues.

## HIV/AIDS

HIV/AIDS information campaigns in Viet Nam have been successful in raising awareness of HIV/AIDS among the vast majority of young people who participated. However, though high levels of knowledge were recorded, accuracy of knowledge was lower. Notable is that nearly one quarter of young people who have never attended school have not heard of AIDS. SAVY shows a clear relationship between level of education and HIV knowledge. SAVY also shows that discussion about HIV/AIDS with young people in the family is often not linked to reproductive health and sexuality issues.

Generally, young people reported positive attitudes to people with HIV, and limited fear. A majority said that they would help and keep normal contact with people with HIV, but would be aware of protecting themselves. However, almost three times as many ethnic minority youth, who have little access to information, said that they would not help someone with HIV/AIDS.

## Substance Use

The environment in Viet Nam provides easy access to legal drugs for young people: a massive 98.6% of the total sample said that they can easily obtain alcohol. Young men are further encouraged to drink through peer pressure, but social constraints discourage the same behavior in young women. Very few young women reported that they had ever smoked, or that they experienced any peer pressure to smoke. However, the opposite is the case for young men, where just under half of young males reported having smoked at some time. The same situation applies to drinking. While many young people have sampled alcohol, the percentage of those who had ever actually been drunk is relatively small, and mostly male, including a small group of young men who repeatedly get drunk.

Data on illicit drug use almost certainly under-reports the real figures, most probably because young people are reluctant to report illegal behavior to interviewers. Also SAVY did not access street youth, migrants and institutional young people and cannot therefore comment on that population of young people who are influenced to use illicit drugs. However, nearly a quarter of the sample said they knew someone who used illicit drugs, and young people from urban areas were twice as likely to know a drug user.

## Health Compromising and Problem Behaviors

Young Vietnamese men are clearly at a greater risk than young women from problem behaviors. Although the actual amount of participation in risk behaviors – such as having unplanned sex, motorbike racing, participation in a group riot, violence and carrying a weapon – were low, there was a clear over representation of males, particularly urban males. Coupled with the data on smoking, heavy drinking, illegal drug use and traffic accidents, the figures for which are dominated by young men, it is very clear that some young urban men are associated with multiple risk behaviors.

In terms of self harm young males had a higher rate than young females, although the overall rate is relatively low. Of the total sample of males and

females, 3.4% said that they had thought about suicide. Of note here is the higher percentage of young females reporting this seriously harmful thinking. However, a high percentage of young people have a group of friends with whom they keep regular company and it is clear that these friends provide peer pressure that is positive and protective, and encourages young people to avoid or resist behaviors such as drinking, causing trouble and watching pornography.

## Accidents, Injury and Physical Harm

Over half of the total sample of 14 to 25 year old Vietnamese young people, including school aged children, had ridden a motorbike, and this increased greatly in urban areas and among young men. Of those motorbike users, only just over 25% reported wearing a helmet and one in four urban young people have had a traffic accident. Understandably the highest proportion of injuries and harm come from motorbike use, and that traffic accidents pose a major risk for urban young people.

SAVY provides a picture of young people's general feeling about their physical health. Digestive problems were the most commonly reported disease across all groups of young people and the youngest urban group reported the highest percentage of vision problems. The majority of those young people experiencing illness sought medical help, and the highest percentage of these bought medicine for self-treatment.

## Mental Wellbeing, Aspirations and Expectations

SAVY creates a picture of young Vietnamese people as resilient, hard working, strongly connected to family and ambitious. They have high expectations, strong self-esteem, value themselves and feel valued by family. While they tend to feel that they have a voice and are usually listened too, they also see a role for greater participation in the society. However, the results do indicate that some young people feel alone and worry about the future. As many as one in five have at some time felt helpless and hopeless about the future. Clearly some young people see a better future than others, and those living in more



difficult circumstances see their future reality as less positive than those who are better off.

Generally young men were more positive and more optimistic than young women about themselves, their future prospects and family. In terms of future aspirations, employment, income and financial success are of major priority to most young people. Family and happiness take second place. The majority of respondents expected that their lives would be much better than their parents.

## Conclusion

Vietnamese youth today are both optimistic and hopeful. They see their future and their opportunities to be brighter than that of their parents. They value school and work, and most are not involved with behaviors that will harm them. However Viet Nam is in the midst of dramatic social and economic changes that will create new risks as well as opportunities. With increased wealth comes exposure to opportunities that will increase the risk, whether of drugs, commercial sex work, interpersonal violence or emotional distress. The potential risks can be seen when comparing Vietnamese youth's health and well being with that of many of our neighbors. Today Viet Nam has relatively low substance use, low interpersonal violence, infrequent suicide attempts, and low sexual risk behaviors. Viet Nam also has very high work and school aspirations. The goal must be to maintain the health and well-being of Vietnamese youth, while at the same time improving economic and social opportunities for them.



# PART I

## Introduction and Methodology

### Chapter 1

## SAVY Overview

This Report of the first Survey Assessment of Vietnamese Youth (SAVY) represents a landmark in the progress of adolescent and youth development in Viet Nam. The findings from SAVY, the first nationally representative survey of young people aged 14-25 years, are intended to better inform future initiatives to promote the healthy development of youth across the country. This includes policy and programs not only in the adolescent and youth health area, but also in defining the role of family and community, education, employment, and culture and information.

According to SAVY, the majority of Vietnamese young people are hardworking, strongly connected to their families, optimistic about the future and generally satisfied with their employment situation. In the main, young people enjoy the schooling experience and feel well treated by teachers. Few of them are engaged in behaviors that are culturally or socially unacceptable. The majority do not support premarital sex, instead choosing commitment, love and marriage before sexual relationships. There are however clear gender differences, with more males involved in risk behaviors, notably smoking, drinking, unsafe sex, motorbike racing and violence. A small but important group of young people face other risks, such as early school drop-out because of economic inequalities and the emerging pressures of development.

SAVY highlights the crucial role of the family in developing young people's characters, providing opportunities for economic support, a harmonious environment, an openness to discuss issues of puberty, relationships and HIV, and positive role modeling by parents. All these factors contribute to greater resilience and resistance to risk behaviors by young people.

The report's recommendations include strategies to build more supportive environments for young people, and for reinforcing existing positive social and health behaviors. It documents the resilient spirit of, and the high levels of optimism about the future by, young Vietnamese. It also highlights the need for targeted interventions to tackle specific health issues and social disparities for young people at risk.

SAVY has been a collaborative effort involving the cooperation of many agencies, and a remarkable degree of cooperation from thousands of young people throughout the country. The SAVY results reported here should be seen as a beginning rather than an end. It is the start of an ongoing process of monitoring social and economic conditions among youth that is currently being improved.

### 1.1. General Introduction to Viet Nam

Viet Nam covers an area of 331,000 km<sup>2</sup>, three quarters of which is made up of mountainous and hilly regions. The Red River delta in the North and the Mekong delta in the South are the two largest low flat deltas upon which 40% of the Vietnamese population lives.

There are more than 54 ethnic groups of which the Kinh is the majority (86%), followed by four other groups that have populations of more than one million: Tay, Thai, Muong, Kh'mer (National Census 1999). Vietnamese is the official language. With a population of 80.6 million, Viet Nam is the world's 14th most densely populated country. More than 75% of the population lives in rural areas and are engaged in agricultural work. Population growth in the years 1989-1999 was 1.64%.

The development of Viet Nam has been strongly influenced by Confucianism and Taoism. The main religions<sup>1</sup> are Buddhism (7.1 million followers), Catholicism (5.1 million followers), Hoa Hao (1.2 million followers), Cao Dai (0.9 million), and Protestantism (0.4 million).

Viet Nam has seen dramatic social and economic change as a result of "*hỏi môi*" policy introduced in 1986. Average annual growth rate was between 7-7.2% during 2002-2003. GDP has doubled between 1990 and 1999<sup>2</sup> and is over US\$ 400 presently. Although substantial progress has been achieved, Viet Nam is still a poor country, with 28.8% of households categorized as living in poverty in 2002. To address this issue, the Viet Nam Development Strategy aims to develop the country economically but still maintain social equality. Poverty reduction is one of the government's priorities. In 1993 there were 58% households categorized as living in poverty and this declined to 37.4% in 1998 and 28.8% in 2002. Viet Nam's Human Development Index is 0.688 which is as high as that of many other well-off countries. The adult literacy rate in 2002 was 94.3%,<sup>3</sup> and life expectancy in 2003 was 68.8 years.

Infrastructure investment and development nationwide is costly, and has been hampered by



unfavorable geographical characteristics. One outcome of this is social and economic inequality, especially between the Kinh population and ethnic minority groups. The Vietnamese government is clearly aware of this situation, and has undertaken a series of prioritized programs for the development of remote and mountainous areas.

Integration and an open policy have brought undoubted social and economic achievements. However it has also created some negative changes in the way people live, and increased social problems, notably substance abuse, sex work, HIV/AIDS, family breakdown and increased individualism in a competitive market.

## 1.2. Youth

Youth development is a compelling concern, both locally in Viet Nam and in countries around the world. In Viet Nam specifically, young people between the ages of 14 and 25 are currently the largest demographic segment (24.5% of the total population as shown in 1999 Census). As young Vietnamese have tremendous potential to promote the country's advancement and success, understanding the issues that are central to young people's development is of critical importance.

Although there are some universal attributes of adolescence as a developmental stage, many aspects of adolescence and youth are culturally specific. In Viet Nam, adolescence is a relatively new phenomenon: as age is generally associated with wisdom, power, and authority, young people are often viewed as needing direction and regulation from adults to monitor their behaviors.

However, the definition of adolescence and youth in Viet Nam is evolving. Young people are beginning to assert their identities and legitimize the concept of adolescence in Viet Nam, fueled by the dramatic social and economic changes occurring with "*hỏi môi*" and the globalization that has ensued. Adolescence and youth as a social and developmental phenomenon shifts in concert with the changes of the economic climate: young people become immersed in a culture of increased tourism, mobility, and improved living standards, where education becomes increasingly valuable and employment becomes more scarce. All of these dynamics shape

the climate in which young people develop.

### 1.3. Survey Assessment of Vietnamese Youth

SAVY not only highlights the youth agenda, but also creates a body of knowledge about Vietnamese youth. Specifically, it aims to:

- provide information that can best inform future initiatives to promote the healthy development of youth across the country;
- inform policy and program development in the Adolescent and Youth Health area in the immediate future; and
- provide baseline data about Vietnamese youth to identify trends and patterns in the coming years.

SAVY is a collaborative effort between many agencies and young people. It is the result of extensive investment and partnership building between the Vietnamese Government through the Ministry of Health (MoH), the General Statistics Office (GSO), and United Nations agencies, notably the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF). Several other organizations, from a variety of sectors, also contributed to the endeavor, notably the Ministry of Education and Training (MoET), the Central Youth Union (YU) and the Viet Nam Women's Union (VWU). In order to ensure that the survey was methodologically sound, the East-West Center (Honolulu, Hawaii) provided intensive technical assistance. Although information about Vietnamese youth was available prior to this survey, it was not comprehensive enough to support the design of well-informed programs, and many interventions and services for youth therefore remain largely inadequate and inequitably distributed.

Resolution No4 by the Central Party Executive Committee, Session VII emphasises "The work with youth is highly important to the country, a decisive factor to the success of our revolution". In the *Viet Nam Youth Development Strategy 2010*<sup>4</sup>, the Government identified employment and prevention of HIV/AIDS and substance use, as the key issues faced by young people in Viet Nam. Although data from SAVY indicate that young people agree about



the importance of these issues, they suggest that youth are concerned about other issues as well. SAVY provides nationally representative baseline data from which we can draw insight into young people's schooling, working lives, awareness and knowledge of HIV/AIDS, drug use exposure, experiences of health, injury and violence, access to mass media, relationships with friends and family, and their attitudes, perceptions and aspirations for the future.

### 1.4. Defining Adolescents and Youth

According to WHO, 'adolescence' has been defined as the period from age 10-19, 'youth' refers to those aged 15-24, and the term 'young people' is often used to refer to the combination of the two groups (ages 10-24)<sup>5</sup>. SAVY, however, surveyed those between the ages of 14-25, for several reasons. Firstly, this age range was deemed to be an accurate representation of a typical young person in Viet Nam today. More importantly, this was deemed the most appropriate age range to allow consistent administration of the survey. As the survey was administered in the absence of parents, young people over 14 were considered old enough to deal with some of the sensitive content explored in the survey without having their parents present. In this SAVY report, the term 'young people' refers to the age group 14-25 years.

Although it would still be valuable to explore the views and experiences of young adolescents between the ages of 10-13, SAVY results indicate that the defined age range was the most

appropriate in exploring adolescence in Viet Nam. For example, according to SAVY the average age of menarche (or first menstrual period) is 14.4 for Vietnamese girls. Comparatively, girls in the United States of America (USA) begin menstruating at an average age of 12.5 years<sup>6</sup>. Similarly, youth in Viet Nam tend to report delays in social and emotional development, as compared with youth in Western countries. While 33% of young urban men in Viet Nam between the ages of 22 -25 report being sexually active, the proportion exceeds 90% of young men aged 20-24 in Great Britain<sup>7</sup>.

As a result of the broad age range in the study cohort, the SAVY findings are often discussed in the context of three sub-groups delineated by age (14-17, 18-21, and 22-25). This enabled clear comparisons of age-specific social and biological changes across sub-groups. For example, though most young people go through puberty during the 14-17 year period, the average age for a first sexual encounter, of those who had experienced sexual relationships, is closer to 20 years of age. Marriage was reported more frequently in those between 22 and 25 years of age. Had the survey not included this upper range of respondents, it is unlikely that SAVY would have provided much information about the marriage habits of young Viet Nameese.

### 1.5. A Risk and Protective Factors Framework

Adolescence is often characterized as the search to answer one key question: “Who am I?”<sup>8</sup> In their struggle to define their identities and their journey through these transition years, adolescents strive to develop and solidify a system of values, become more independent, and cope with many physical, emotional, and social changes.<sup>9</sup> This is also a time when young people experiment with riskier behaviors, and although most young people emerge from the transition unscathed, some can engage in health-compromising activities. Many worldwide programs that strive to prevent high risk or dangerous youth behaviors utilize the risk and resilience model, which focuses on reducing factors known to increase the potential for problem behaviors (‘risk factors’), while emphasizing those factors known to promote resilience, or young people’s capacity to cope in difficult times (‘protective factors’)<sup>10</sup>.

Considering young people within the context of their own family dynamics is a useful lens through which to consider the values of the risk and protective framework. SAVY establishes that most young people, even those in difficult situations, appear to remain connected to family, are prepared to work hard for their families, respect their families, and look forward to having a family of their own. These are all significant protective factors that can strengthen young people’s self-esteem and boost resilience. At the same time, there are adolescents who are not connected to their families, and this can pose potential problems in terms of the status of their physical and mental health.

This report strives to ground SAVY findings in the risk and resilience model. SAVY indicates that youth in Viet Nam face many challenges, notably traffic accidents, tobacco and alcohol use, unprotected sexual activity, interpersonal violence, and mental health issues. Additionally, the findings from SAVY identify that there are a number of protective influences that mitigate the risks faced by young people in Viet Nam, such as having a strong support network in friends, family and community. In applying this framework to program and policy development, attention should be focused on prevention strategies which minimize known risk factors and which encourage the development of those factors known to be protective.

At the same time, it is important to realize that there are specific populations of young people that are particularly vulnerable, including those living in poverty, the never-schooled and school drop outs, those from ethnic minority backgrounds, and, in some cases, those in remote areas of the country. Additional research on vulnerable youth populations identifies street children, victims of abuse, young sex workers, and young people with addictions as particularly high risk, although SAVY did not specifically seek out these sub-populations when it was administered.

### 1.6. Snapshot of Priority Issues

SAVY data highlight a number of areas where effective intervention could reinforce positive and protective factors, and improve the lives of young



people:

- **Promote the positive behaviors of youth:**

The generally positive findings from SAVY require due acknowledgment, and necessitate the development of strategies to maintain and further promote safe, sensible and positive behaviors and attitudes. Focusing on the reinforcement of young women's smoke-free lifestyles; encouraging monogamy and fidelity in marriage; further building opportunities for strong family connection; and providing opportunities for young people to be listened to and have a say, are all tools that can be used in any positive behavior strategies. Traditionally these approaches have not been politically attractive, but given the apparent strength of protective factors (education, family and friendships) in the Vietnamese community, the development of positive behavior strategies emerges as a priority issue for the future.

- **Poverty and employment:** Focusing on opportunities for work and enterprise for young men and women, within local areas, can decrease the number of families living in poverty, and may reduce the need for migration and its associated risks for young men and their family. With a growing population of young people and estimates that 1.4 million new jobs are required each year to keep pace with the population's employment needs, unemployment and underemployment are priority concerns for young people.

- **Ethnic minority youth:** SAVY indicates that ethnic minority young people are at a considerable disadvantage in indicators ranging from education and vocational training to the ability to access information about reproductive health and HIV/AIDS.

- **HIV/AIDS:** 50% of new HIV infections occur in young people, and 40% of people living with HIV/AIDS (PLWH) are between the ages of 15 and 24<sup>11</sup>. In Viet Nam, 62% of infections are in the 20-29 age group. SAVY shows that young people hold a broad range of opinions on topics related to the spread of HIV/AIDS, including views on premarital sex, condom use and appropriate treatment of

PLWH. It is important to recognize that, although cultural taboos often limit discussions about these sensitive issues, young people must have the opportunity to explore their options in a safe arena so that they can make responsible choices in the future. Focusing HIV efforts on the most vulnerable young people, such as intravenous drug users (IDUs) and young sex workers, is the most effective way to halt the spread of the disease<sup>12</sup>.

- **Gender:** A young person's gender appears to either increase or moderate risk for different issues. For example, young women tend to communicate more openly with their families, and they use substances far less than their male counterparts. Therefore attempts to intervene in young men's smoking, using programs that are peer based for example, may save many lives in the future. At the same time, however, girls are less positive than boys about their futures and themselves. Promoting gender equality in schools can provide inroads for young women to access financial opportunities and gain equitable employment. Increasing girls' access to education and services through Life Skills Education and Youth Friendly Health Services will help increase their reproductive health knowledge, which can have positive effects on a young woman's decision-making in regard to family planning and on maternal mortality.

## 1.7. SAVY Report Format

This report is the first in a series to publish the SAVY results. The descriptive data are provided in Part II of the report, focusing on a wide range of issues concerning adolescents and youth. Each section is presented with data delineated by age, gender, and ethnicity, and, where relevant, marital status (never married and ever having been married). This is followed by discussion and a limited analysis. Where no notable difference exists between groups, this has not been stated explicitly. Where relevant, reference to lack of gender or age difference may be made.

Disaggregation of the category 'ethnic minorities' includes all ethnic minority groups reported by

respondents and accounts for 15% of the total sample. While such a category may conceal inter-ethnic differences, further disaggregating was not practical as this would have resulted in insufficient numbers for analysis.

Linkages between issues are identified where possible. A later and much briefer section explores those factors associated with increasing involvement with health compromising behaviors and those factors that are associated with lower involvement. It is important to note that while the report provides some analysis of the results, there may be other valid explanations for these results. The information presented is certainly subject to further debate and additional scrutiny.

Subsequent to this report, there will be ten policy briefs on topics related to youth development (HIV/AIDS, reproductive health, gender, employment, family life and culture, education, substance use, injuries and violence, services, and wellbeing and mental health). These briefs will further explore the implications of the data and provide more intensive policy and statistical analysis. Together, these publications will enable well-informed policy and program development for the present time. In addition, the data will provide a baseline for Viet Nam to identify trends and patterns in the coming years, informing and strengthening policies and programs in the distant future.

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## Chapter 2

# Methodology

## 2.1. Sampling Frame and Sample Size

The SAVY sample is a national representative sample of youth (persons ages 14-25) living in households across the eight economic regions of Viet Nam. The sample was drawn from the sub-sample of 45,000 households in the 2002 Viet Nam Living Standards Survey (VLSS 2002), with a multi-staged and stratified design. The youth in the SAVY sample design are sufficient to represent the nation as a whole, as well as the urban and rural sectors separately. The largest cities (Hanoi, Ho Chi Minh City [HCMC]) were over-sampled in order to provide for increased statistical power in that segment of the total population of youth.

Forty-two out of 61 provinces were selected for the SAVY sample<sup>1</sup>, using the probability proportional to size (PPS) method to maintain representativeness. At the next stage of sampling, enumeration areas (EAs) in each province were selected. In those EAs sampled, all youth aged 14 through 25 were identified (i.e. those born between 1978 and 1989, males and females, married and non married from the 20 households that had been selected for the Vietnamese Living Standards Survey [VLSS] 2002). The youth cohort represents all youth, but not those living in special arrangements, such as barracks, re-education centers, social protection centers, factories and dormitories.

The 61 provinces in the VLSS 2002 sample included 2,250 EAs, and the 42 provinces selected for SAVY included 1,643 EAs. From these, a total of 446 EAs were selected for the SAVY sample. These EAs contained 8,920 households corresponding to a population of 40,140 (about 4.5 persons per household). Since youth aged 14-25 account for 24.5% of the total population (the figure in the 1999 census), the anticipated number of youth in the SAVY sample was approximately 9,835. If the mobilization rate (percentage of eligible youth actually interviewed) was 90% then the number of youth interviewed would be estimated to be about 8,850. In the actual SAVY field experience, the mobilization rate was 85% and the number of completed

interviews was 7,584.

The sample is therefore representative, and provides sufficient cases for analysis at the national level, within urban and rural sectors at the national level, by gender at the national level, and for each of the regions. Further detail on the sampling methodology is provided in the Appendix.

The SAVY mobilization rate is not low by the standard of such surveys of youth, and is only slightly lower than the GSO had expected. It should be noted that this is the first time this methodology has been used for a national survey. SAVY has certain characteristics that could lower the mobilization rate, particularly in the fact that its sampling frame was derived from another survey using household lists created one year earlier, in the way that local people's committees were called upon to mobilize youth, and in the relatively high rate of geographic mobility within the youth population.

Among those who did agree to go to the central location for interviewing, almost no one refused to answer the questions or fill in the self-completed part of the survey. The survey method (face-to-face interview with a self-administered second part), the quality of interviewers and the organization of the field work, including extensive supervision, were important factors that ensured the quality of the SAVY data.

## 2.2. Questionnaire

The questionnaire was designed through a very dynamic process, where experience from previous surveys was examined and opinions of young people were actively solicited to ensure quality and relevance. This process also helped to define the methodology and implications for fieldwork planning.

A number of stakeholders' agencies, including research institutes, were involved in the development of the questionnaire. This process ensured broad participation and ownership of the questionnaire and the survey.

The questionnaire design took place in two stages. In the first stage, experienced researchers, and others interested in the survey as stakeholders, were convened to a workshop by the MoH. Potential

topics, and the possible phrasing of questions using the questionnaire bank from previous studies in the region as reference, were fully discussed. Since some of the topics were deemed to be more sensitive than others, it was recommended that the questionnaire should be organized into two parts, one for an interview and the other for self-completion. On the basis of that workshop, a draft questionnaire was created for review by the workshop members and numerous others in stakeholder agencies, as well as by young people through a series of consultations.

Eight focus group discussions were conducted in Hanoi and HCMC, with around 60 young people of different ages in the 14-25 range who were either married or unmarried and either attending or not attending school. Participants gave detailed feedback about the terminology, the ways in which questions were posed and the sequencing of the questions, as well as which specific questions or issues they would prefer to respond to on their own, rather than with an interviewer. This process resulted in the rephrasing of a number of questions and changes to the self-completed section.

Preliminary training was conducted for field-testing of the questionnaire. Participants came from the GSO Office in Tuyen Quang, Hue and HCMC, representing the north, south and central regions of Viet Nam. A group of 50 young males and females, either married or unmarried and either attending or not attending school, participated in the interviewers' practice session. In the debriefing discussions, these young people expressed their feelings about the interviews, the questions asked, what they liked and did not like about the process, seating arrangements, ideas of what topics/issues they thought might still be missing in the draft questionnaire, and what they thought would be needed to make good interviewers. Field testing with around 180 young people from six communes in these three provinces then took place.

The second stage involved further vetting of questionnaire sections and was coordinated by the GSO. The review meeting following the field trips recommended the need for another field testing exercise, particularly because little experience had been gained from testing with urban young people and interviewing ethnic minority young people through interpreters. Following the second round of field-testing in Hanoi and Yen Bai, the feedback was incorporated to finalise the questionnaire for the

interviewers training. At the training, further revision and refinement of the questionnaire occurred prior to the field work.

The resulting questionnaire consisted of a total of more than 200 questions. SAVY experts then further modified the questionnaire in order to ensure the best phrasing possible, and to avoid technical terms. The first section was conducted as a face-to-face interview, with general questions categorized into topics. The second part of the questionnaire – and the part that makes the survey special – was an anonymous self-administered section, including 52 sensitive questions that youth preferred to answer in private. Originally, it was envisaged that the self completed section would contain between 10-15 questions, but it became much longer as the youth consulted suggested that a lot more questions they perceived to be sensitive should be placed there. The questionnaire could be completed in 60 to 80 minutes, though this was longer for those unable to read the questionnaire and who required translation.

The specific information collected through the questionnaire includes:

- Personal demographics
- Schooling, education
- Vocational training, Work and employment
- Puberty: knowledge and behaviors about reproductive health
- Dating and friendship
- HIV/AIDS
- Injury, illness and physical health
- Attitudes, perceptions and behaviors
- Social factors and emotional wellbeing
- Mass media
- Future aspirations.

The complete questionnaire is found in the Appendix.

## 2.3. Survey Method

Data from young people were collected by assembling them together in a public space away from their homes (such as a people's committee office, or the cultural house of the hamlet), but still arranging for privacy during interviews. The fact that youth were asked to gather in one place had the potential to affect the response rate. To minimize this, the GSO





coordinated very closely with the Women's Union, the Youth Union and the local government, informing them about the purpose and importance of the survey so that they would then mobilize youth effectively.

An interviewer of the same sex, sitting side-by-side, interviewed young people, a method that had previously been tested during the training and testing phases. The face-to-face interview was of assistance to respondents who were generally not familiar with questionnaires and the coding of the responses. The interviewers checked the respondents' ability to self-complete the sensitive part (through interviewing and checking levels of education) and gave clear instructions on how to fill in the questionnaire before handing it over to the respondent.

After finishing the anonymous questionnaire, respondents were asked to post them in the box provided. This procedure was designed to ensure and demonstrate the privacy of the information.

## 2.4. Training and Field Data Collection

A central steering committee for the survey was established with members from the GSO, MoH, WHO, UNICEF, YU and WU.

Since this was a sociological survey asking for information covering a wide range of areas, including sensitive issues, the training to ensure high quality field staff was considered crucial to the quality of the results. Three training courses, over five-day periods including one day of practice, were organized by the GSO for 150 recruited data collectors. These collectors

were GSO staff from provincial offices.

Skills covered in training included how to communicate with youth, the specific content of the questionnaire, the underlying intent of each of the questions, and specific instructions for coding responses. The training methods included classroom instruction, group discussion and hands-on practice. More than 150 youth from different social backgrounds were invited to the sessions so that interviewers could practice interview skills and fieldwork procedures. Feedback from the young people was very valuable for both the instructors and the trainee interviewers. Only trainees who passed a post-training examination were allowed to participate in the survey.

Field data collection took place over 53 days. The trained interviewers were organized into 19 teams. The field schedule was prepared detailing the expected itinerary and travel of each survey team between EAs, districts and provinces. The People's Committee at commune level, through the YU and WU, provided notice to young people and mobilized them to participate in the survey.

## 2.5. Survey Errors and Limitations of the Data

The statistics in this report are estimates (also referred to as indicators) derived from SAVY, which is a sample survey. There are two types of error that occur in sample survey estimates: sampling and non-sampling. Sampling errors occur because the observations are made from only a sample of, rather than the entire, population. Non-sampling errors can be attributed to many sources. The joint effects of sampling and non-sampling errors determine the accuracy of the sample survey results. When a sample survey is designed using probability sampling techniques, it is possible to assess the sampling error associated with any particular estimate by using the survey data themselves.

## 2.6. Non-sampling Error

Non-sampling error is more difficult to quantify than sampling error because it has many components, each one of which requires its own evaluation study to assess effects on the survey results. Among the many sources contributing to non-sampling error are (1) non-

response from some of the households and/or persons selected to participate in the sample; (2) conceptual and definitional difficulties in the design of the questions that are asked of the respondents; (3) inability or unwillingness to provide correct information on the part of respondents; (4) mistakes by interviewers and data entry staff in recording or coding the data obtained; and (5) other errors of collection, processing and coverage. The evaluation of non-sampling error is also constrained because the statistical theory for doing so is underdeveloped compared to that for sampling errors, and also because there is an absence of knowledge about the true values in the target populations under study. For these reasons the designers and producers of large-scale surveys, including SAVY, rarely provide empirical results showing the type and magnitude of non-sampling error that may be present. Survey budget constraints effectively make its assessment infeasible.

Instead, efforts are usually directed at controlling and minimizing non-sampling error through such means as using previously validated questionnaire items, pre-testing of new questions, pilot testing of survey methods and operations, careful and intense training of interviewers, sample verification of data entry and coding, plus close supervision, observation and spot-checking in the field. All these steps were taken during the SAVY operations. Nevertheless it is important to describe, where known, the kinds of non-sampling error, or biases, that may be present in the data and to indicate, qualitatively, what the effects of these may be.

An important source of non-sampling error in SAVY is non-response. Its magnitude is measured by the non-response rate, calculated as  $(1 - I/n)$ , where  $I$  is the number of youth 14-25 for whom interviews were obtained and  $n$  is the number selected in the sample. In SAVY there were 7,584 interviewed youth and 9,989 selected-for a non-response rate of  $(1 - 7584/9989)$ , or 24.1%. This level of non-response is in line with the experience of other surveys focused on youth age groups. Moreover, the SAVY field design eliminated non-response at the household level, an additional source of non-response in most other surveys. The cited level of non-response can have a significant biasing effect on the results because without additional information we can only assume that the non-responding youth are similar, in terms of their characteristics and distribution, to the responding ones—an assumption which cannot be independently

verified. Comparisons between survey distributions and distributions available from other sources, notably the Health Surveys and the national censuses, suggest only a very limited bias is involved, though one exception should be noted. The SAVY sample of young people may slightly under-represent those in the older part of the age range who are married or who are working, or who are not enrolled in school. This is apparent in comparisons of age and sex-specific percents single, enrolled, and working, in SAVY versus in the 1989 and 1999 censuses. This bias should not have much effect on analysis of SAVY data, but must be kept in mind nevertheless.

## 2.7. Standard Errors

The particular sample used in SAVY is one of a large number of all possible samples of the same size that could have been selected using the same sample design. The particular value of the estimate – the point estimate – derived from each of the different samples would differ from each other. The deviation of a sample estimate from the average of all possible samples is called sampling error. While it is not possible to calculate the actual sampling error since we only have data from one of the possible samples, the standard error of a given estimate as calculated in this report is nevertheless an estimate of the sampling error. The estimated standard error also partially measures the effect of some non-sampling errors such as that which can be attributed to variability among interviewers and coders but does not measure any systematic biases in the data.

The point estimate from the sample for a given variable or indicator, and an estimate of its standard error, permit us to construct interval estimates with prescribed confidence that the interval includes the average result of all possible samples. To illustrate, if all possible samples were selected, each were surveyed under the same conditions and an indicator and its estimated standard error were calculated from each sample, then approximately 95% of the intervals from two standard errors below to two standard errors above the indicator would include the average value of all possible samples: the so-called 95% confidence interval. Details about standard errors can be found in the Appendix.

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1. At the time of the sample selection there were 61 provinces; however at time of printing Viet Nam has 64 provinces.

# Part II

## Findings

### Chapter 1

## Young People as Part of Vietnamese Families

This survey provide some glimpses of Vietnamese family life that are very important from the standpoint of youth and the role of families in young people's lives.

### 1.1. Family Composition

Rural families are much larger, both because they are more complex and because they have larger numbers of children. Urban young people reported 2.7 siblings compared to 3.6 for the rural respondents, with family size reported as 5.1 for urban and 5.4 for rural counterparts. This means that family resources are shared in rural areas among a larger number of people. One important resource is space, and especially private space, which takes on importance, as teens grow older. Having one's own room is uncommon among rural males (24%), but somewhat more common among rural females (34%). More urban males at about one-third or so have their own room, but 46% of urban females do. It must be recognized, however, that respondents may be overstating their access to a completely private space within their homes.

Many young people report that they are not co-resident with their siblings. This is seen in urban areas where average siblings number 2.7 but young people report resident siblings of 1.6. In rural areas, the average sibling number is 3.6; however young people co-reside with an average of 1.9 siblings.

Suggested reasons for this include married siblings leaving home and older siblings moving away to seek work, especially those who move to urban areas where there may be more job opportunities.

### 1.2. The Economic Background of Families

The economic gap between urban and rural families, as reported in SAVY, is enormous and shapes all else relating to economic circumstances. The economic situation of young people's families, or family material conditions (FMC), has been calculated using a combination of variables including ownership of goods, water and electricity source. Table 1 shows the comparative economic situations for young people from four different geographic locations. Respondents were categorised into three different groups (about 1/3 in each) with group number 1 being those with lowest family material conditions or the poorest group, and group 3 being those with the highest materials conditions or the "better off". 85.1% of young people living in large urban cities belong to a family with high material conditions compared with about half this number of 41.8% of young people living in towns. Being well off is uncommon for rural young people with only 13.8% of rural young people classified in the higher FMC group. Few young people from ethnic minority families have high family materials conditions (3.3% compared to 40.4% of Kinh counterparts).

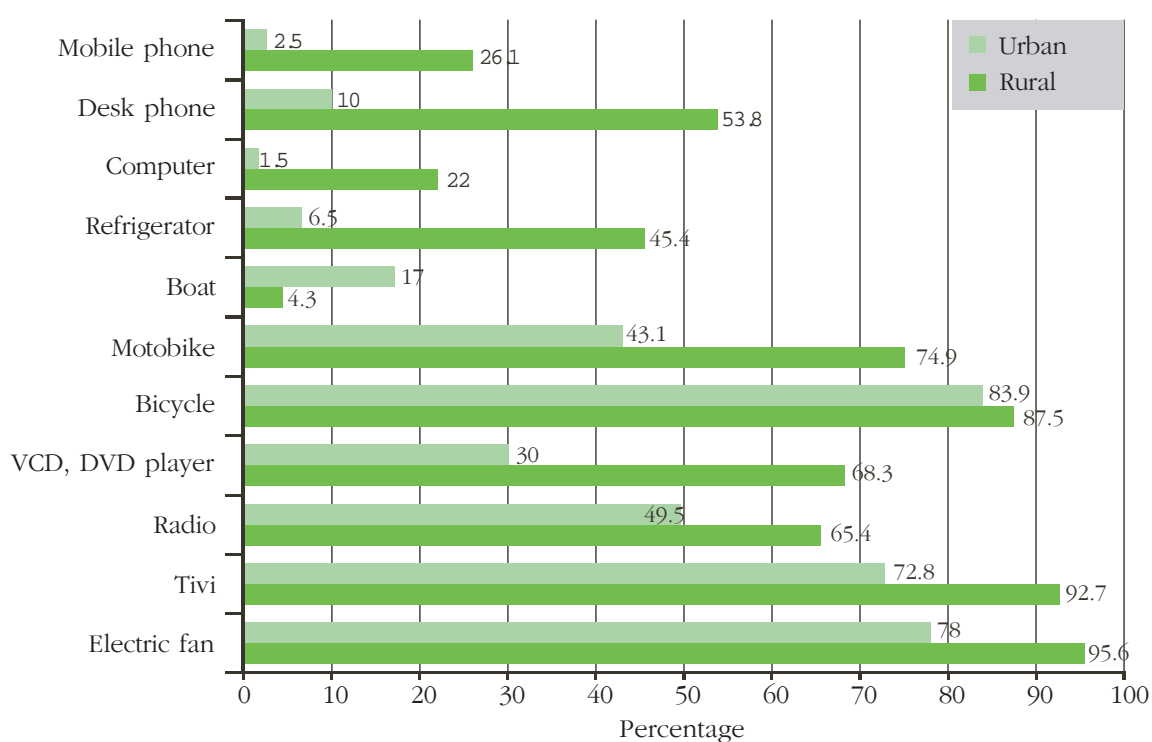
SAVY results support the claim that, despite the period of economic growth between 1993-1998, Viet Nam is still a poor country<sup>1</sup> with many young people, especially from rural and ethnic minority areas, reporting limited family ownership of certain items. Ownership of some items is relatively equal,

**TABLE 1** *Comparative Economic Situations*

Site \ Level	Family Material Conditions			
	Lower	Middle	Better off	Total
Big Urban cities	26 1.9%	176 13.0%	1155 85.1%	1357 100%
Urban cities	17 4.8%	89 25.3%	246 69.9%	352 100%
Towns	206 21.6%	349 36.6%	398 41.8%	953 100%
Rurals	2142 43.5%	2099 42.6%	681 13.8%	4922 100%
Total	2391 31.5%	2713 35.8%	2480 32.7%	7584 100%

while it is extremely unequal in others. For example, bicycles are owned by 80-88% of families in both rural and urban sectors. However, radios are owned by 65% of families among urban youth compared to around 50% of rural youth families; electric fans and TV sets are owned by 95% of urban youth but only 75% of rural youth; refrigerators are owned by nearly half of the families of urban youth, but by only 7% of rural families; and 74.9% of urban families own motorbikes, compared with 43.1% of rural families.

As seen in the graph very considerable differentials are found between urban and rural young people for certain modern, electric items. Over half the urban families have telephones, compared to only about 10% of rural families, and about 24% of Kinh families compared to about 2% of ethnic minority families. Some 22% of urban families have computers, compared to 1.5% of rural families. And the differential for cell phones is similar: 26.1% of urban families but 2.5% of rural families.

**GRAPH 1** *Family Ownership by Urban and Rural Residence*



### 1.3 Intact Parents

The decline in mortality in recent decades must be judged as one of the very positive developments for Viet Nam's families. Among respondents aged 22-25, 14.7% reported the death of at least one parent, compared to only 6.8% among those aged 14-17. This last figure can be considered to be a very recent average level of mortality among parents of those aged 14-17 years. Age at the death of a parent is reported to be mostly in the range of 11-14 years, which are crucial ages at which to have such a disruptive event occur.

A total of 4.7% of respondents reported the death of a parent during childhood (before the age of 14), and this figure is higher in the older age group and for young people from ethnic minority areas: 7.4% of respondents from ethnic minority areas experienced the death of a parent as a child, compared to 4.3% of Kinh counterparts.

In some societies, divorce or separation of parents can account for discontinuity in the experience of family life. The SAVY findings suggest that divorce and separation add only marginally to the overall proportions of youth who report that their parents are no longer still together. The percentage with 'parents intact' ranges from 82.7% among the oldest group of youth to as high as 90.9% among the youngest group. The corresponding percentages, that of both parents still alive, are 85.3% in the oldest group and 93.2% in the youngest. Thus, divorce or separation accounts for about one-third of dissolved parental couples, and parental mortality accounts for about two-thirds\*.

Divorce is not a common occurrence, at 2.6% of the total sample. Yet the rate of divorce for parents of urban youth is 4.7% compared to 2.0% for rural. Increased family conflict may be due to influences of urban lifestyle with fast changes and multiple pressures. Higher divorce and separation in urban centers may be due to more access to information and legal support related to marriage and family affairs than in rural areas. However, as divorce is seen as a risk factor in terms of family stability and connection,

then urban young people may be more vulnerable in this area.

### 1.4. Getting Married

Small proportions of the SAVY respondents reported that they had married. Married respondents were 15.8% of the total sample; 21% of females and only 10% of males. More rural young people were married (17.5%) compared with their urban counterparts (10.4%). This is consistent with other national data and reflects the trend in recent decades toward later marriage. Very few of the youngest cohorts (14-17) were married (0.4%), although this increases to 14.1% for the 18-21 age group and just fewer than 50% of the sample for the 22-25 age group. There is a clear increase in marriage with age for both young men and young women. The average age for marriage is 21 for young men and 19.5 for young women. Stark differences exist among urban and rural young women aged 22-25 with 38% of urban and 68% of rural women being married. This is a significant difference and has implications for the education, health and employment services required to meet the needs of these two different groups.

Choosing one's spouse independently occurs among roughly one-third of those who had married by the time of interview. The other two-thirds shared the decision with their families. The traditional Vietnamese custom of living with the husband's family immediately upon marriage is maintained even in the very recent cohort of young married people. About 75% of married respondents reported that they lived with the husband's family, and another 14% reported that they lived with the wife's family. Only 11% reported that they lived by themselves as a couple, although this was 13.5% for the



\* This is similar to the patterns found among youth in other Southeast Asian countries, such as the Philippines and Thailand. In those countries the mortality source is slightly less important and the divorce/separation source is slightly more important.

22-25 age group and similar for urban and rural. Even so, this 13.5% – or more than 1 in 10 – that live on their own after marriage may indicate a move toward nuclear family-style living arrangements.

When asked whether they were satisfied with married life, between 90-95% of both males and females, in both urban and rural areas, answered that they were “satisfied” or, more often, “very satisfied”. Such high levels of satisfaction are understandable given that most of these respondents are recently married. Yet it is worth noting that in rural areas, and especially among rural females, there are important proportions (approximately 9%) that describe their relationship as “so-so”, or reported that they are ‘unsatisfied’ or ‘very unsatisfied’. Among the married, 5.3% reported having been hit by their spouse. Some 2.7% of males report this, while 6.5% of females reported being hit, with older women 22-25 years reporting at around 8%.

### 1.5. Experience Away from the Family and Home

Living away from home for one month or over has been experienced by both females (32%) and males (27%). The main reasons for living away from home include earning money (46.2%), studying (25.9%) and holidays (17.3%). Rural young people report living away from home more often than their urban counterparts (50.5% compared to 31.2%). The percentage of urban young who live away from home to study (32.6%) is higher than their rural counterparts (24%).

Of those young people who were attending school in 2003, the large majority lived at home while attending school (97.7%). However, for young rural women in the 18-21 age group, only 88.5% lived at home, with 4.7% reporting to live in school dormitories (boarding schools, colleges and universities) and 5.8% with other families. This figure may be under-reported however, as some young people away at school were not available for SAVY interviews. Of the small non-response rate, a significant proportion were unavailable because they were away for work or education purposes.

### 1.6. Connection to Family

Generally high levels of family connection were reported, with 95% of respondents feeling valuable to their families. This result is consistent between males

and females, between urban and rural youth, and across age groups. In fact the strength of family connection reported in SAVY is an important finding and highlights family as a protective factor for young Vietnamese people. Overall young people felt valued by their families and were connected to them. Recent research suggests that even young people who migrate for work remain strongly connected to their family<sup>2</sup>. Family connectedness is dealt with in greater detail in Chapter 11: Mental Well-being, Aspirations and Expectations.

### 1.7. Signs of Discord

Family conflict, defined as remembering frequent quarrels, was reported by 8.9% of the total sample. Of those young people living in families with ongoing conflict, 26.6% reported to have a father with an alcohol addiction. This was much higher than the group of young people reporting ‘no conflict’; 14.6% of this group reported a father with an alcohol addiction.

**GRAPH 2 Degree of Family Conflict with Father's Problem Drinking**



Few young people reported injury due to violence of a family member, at only 2%. However, this was a little higher for males at 2.9% compared to 1.5% for females, particularly for urban young males aged 14-17 years (4.6%).

1. Haughton, Johnathon. Extraordinary Changes in Living Standards During an Economic Boom: The Case Study of Viet Nam 2001 UNDP and GSO. Hanoi: Statistical Publishing House; 2001
2. WHO Adolescent Migrants and Reproductive Health in the Greater Mekong Delta Region. A Preliminary Analysis 2004

## Chapter 2

# Education

The questions respondents were asked relating to education aimed to provide general information about schooling and young people's educational experience. They covered age of attending and leaving school, achievement levels, reasons for non-attendance and school drop-out. A group of questions also explored the school environment in terms of teacher-student relationships, treatment of students, students' satisfaction and enjoyment of learning. Resulting data should not be used as a measure of the effectiveness of specific aspects of the curriculum or the standard of the education system.

### 2.1. School Attendance

Of the young people surveyed, 96.2% had attended school at some time in their lives (98.6% for urban compared to 95.4% for rural young people). This finding is consistent with prior enrollment and attendance data<sup>1</sup>. SAVY found similar primary school enrollment figures for boys (97%) and girls (95.4%). Of some interest is that SAVY found similar enrollment and education achievement figures for young men and women at every level. A small but concerning 3.8% of respondents have never been to school.

44.8% of the sample reported to be attending school at the time the survey took place, including college or university. As expected, more of the

youngest group are in school; 75.2% for the 14-17 age group, decreasing to 27.7% in the 18-21 age group and 7% in the oldest group. More urban respondents were in school (53.4%) than rural (42%). Male participation was a little higher (48.1%), compared to females (41.5%).

Table 2 shows the level of educational achievement attained by young people at the time of SAVY. The most common level of educational achievement for the sample is lower secondary school (49.7%), comprising 53.7% of rural and 38.7% of urban young people. However young people in urban areas are more likely to have achieved upper secondary school level (30.7%) compared with their rural equivalents (21.1%). Another differential found in educational achievement is that twice as many rural students only complete primary school level (20.2%) compared to 9% of urban students.

The SAVY enrollment figures of above 95% are encouraging, though the disaggregated data shows lower attendance and achievement in poor areas, rural areas and among ethnic minorities. Young women from ethnic minorities were the most likely to have never attended school (19%) compared to 2% of their Kinh counterparts. In comparison, 10% of boys from ethnic minority populations have never attended school and only 2% of Kinh boys. Of the total group who had never attended school, 52% were from ethnic minority areas. The right to go to school is written into The Education Law in Viet Nam reflecting the government's priority for education. Viet Nam has announced universalized primary education. Of particular significance is the fact that education is free for primary school children, and that the government has a special policy for children in poor areas.

**TABLE 2 School Achievement Levels**

Level	Location		Ethnic		Total
	Urban	Rural	Kinh	Ethnic Minorities	
Primary school	9.0	20.2	13.9	39.8	17.2
Lower secondary	38.7	53.7	40.9	48.3	49.7
Upper secondary	30.7	21.1	25.8	9.4	23.7
Less than bachelor degree	7.5	3.1	4.7	1.4	4.3
Bachelor or higher degree	13.9	1.5	5.4	0.9	4.8
Did not complete primary	0.2	0.3	0.4	0.4	0.4
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

**TABLE 3** *Reasons for Non-attendance at School*

	Number	Percent
Can't afford school fees	121	44.1
Have to work for my family	73	21.2
Don't want to go to school	38	15.7
Family doesn't want me to go to school	16	5.3
Too ill, disabled	13	4.4
School was too far from home	12	4.2
Don't know Kinh language	9	2.7
Other	5	2.3
<b>Total</b>	<b>287</b>	<b>100.0</b>

According to SAVY the main reason for not attending school is still because families 'can't afford school fees' or schooling expenses (44.1%). These education-related expenses may include text books, stationary, clothing, contributions for school infrastructure and transport. This is followed by 'having to work for my family' (21.2%) (see Table 3). The constraints and difficulties in paying education-related costs and having to work to help families fall far more heavily on those living in poverty, of which young people from ethnic minorities are over represented. This explains to a certain extent why young people from poor areas, as well as those from ethnic minorities, have a significantly high percentage of not attending school (Table 2).

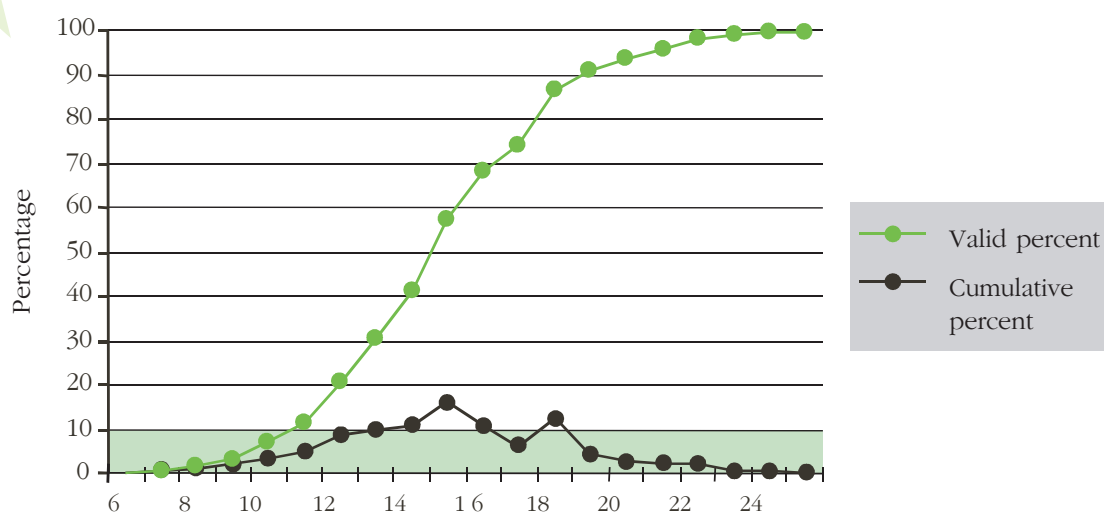
## 2.2. School Drop out Rates

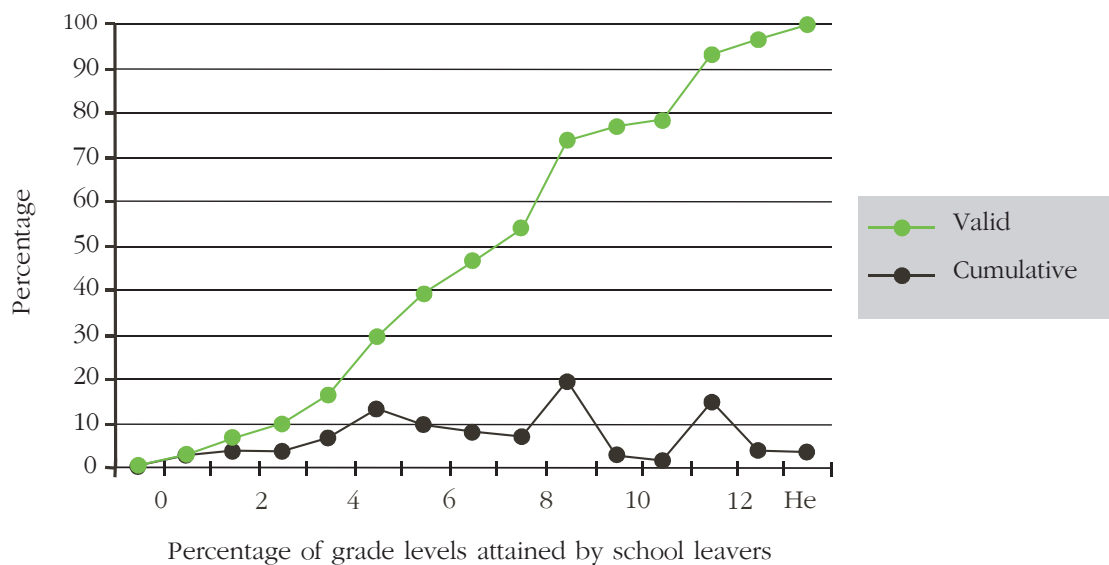
Graph 3 shows that the school drop-out rate is high between the ages of 12 to 16, low at 17 to 18 years and high again at the age of 19. This corresponds to the three education end points: primary, secondary and high school (see Graph 4). Graph 4 indicates that 30% of those who have dropped out of school completed Grade 5, but the cumulative drop-out rate reaches 75% by the end of Grade 9.

The main reasons why young people drop out of school are similar to the reasons for non-attendance, with 25% reporting that they couldn't afford to continue and 20% dropping out to work for their family. A further 13.8% said they did not want to continue studying.

Young people from ethnic minorities are over represented in non-school attendance and in drop out figures. For example, 28.8% of those in the sample who had stopped school reported to have only achieved primary education level, but this increases to 53.3% of ethnic minority compared to 24.8% of Kinh. The disadvantaged situation of ethnic minorities and the high rate of ethnic minority drop outs are listed as major challenges to be met in the 2001-2010 Education Development Strategy.<sup>2</sup>

However there are also other reasons, failure in studies is a significant reason for drop out too, reported by 13.5%, and 6% identified their limited

**GRAPH 3** *Drop out Rate by Age*

**GRAPH 4 Drop out Rate by Grade**

abilities to study or attend school as a reason for dropping out. When combined, failure in studies and poor academic skill account for 20% of school drop outs, which is relatively high. Because failure and lack of success have been identified as behavioral risk factors for young people, the findings are a useful indicator for the school system to explore ways in which young people can be encouraged to stay in the more protective school environment.

To some extent, the education system is challenged to accommodate the needs of every young person in Viet Nam, and this obviously affects the drop out rate particularly for those in disadvantaged areas. In order to continue on to secondary level, young people from ethnic minorities must often leave home for boarding school, as there are few high schools in mountainous areas. High schools that are situated in the plains (delta) areas can only take limited numbers, and national entrance exams limit their admissions. Young people from ethnic minorities and from poor areas – who are already disadvantaged by economics, by having to travel long distances to school, and often by being educated in a language other than that used at home – are least likely to pass these exams. They are also least likely to afford the additional costs of studying away from home. Awareness of these educational difficulties and inequalities has resulted

in special government arrangements including incentives, differential standards and economic subsidies for young people coming from disadvantaged areas. However it is difficult to achieve equity over night.

As a final note, although many other countries have identified school bullying as a significant influence on the school drop out rate, this does not appear to be the case in Viet Nam according to this survey.

### 2.3. Literacy Rates

Participants were asked about their level of literacy and their access to building skills in literacy in their current school. The urban literacy rate was 96.9% and the rural was 91.5%. Among the 96.2% of young people having gone to school, 92.8% know how to read and write, meaning that 3.4% are illiterate. Those who had not finished primary school (16.4% of those who have dropped-out of school, and 8.7% of all surveyed youth) are particularly vulnerable to re-illiteracy.

### 2.4. Private Tutoring

Young people in school and full time study were asked about private tutoring. There is an extremely high percentage of private tutoring recorded outside



**GRAPH 5 Access to Private Tutoring**

of school hours by this group of young people (69%). As very few young people in the 22-25 age group were in full time study (n=14), private tutoring really relates to the 14-21 age group, of which 70% reporting occurrences of private tutoring. More private tutoring was reported in urban areas and with Kinh young people (78% urban, 66% rural, 74.3% Kinh, 31.7% ethnic minority).

The reasons for such high levels of private tutoring could include the improved economic situation of families, increased pressure and competition to succeed at school, the quality of student performance and tutoring as a de-facto salary for teachers. The reasons for the discrepancies between urban, rural and ethnic minority young people may include economic factors, availability of tutors, differing priorities and values placed on formal education.

## 2.5. Perception of Schools and Teachers

Those young people who were currently studying in school or university were asked a number of questions about their attitudes and perceptions toward schools and teachers. Overall the findings are extremely positive across regions, age groups, ethnicities and gender. 90% of students agreed that teachers treated all students equally, although boys agreed at higher rates compared to girls (92% versus 87%). However, 25% of older female students (22-25) disagreed with the statement. 90% of students reported that they had the opportunity

to 'have a say' at school. This is similar to a UNICEF study on youth participation and opportunities for speaking out in school<sup>3</sup>. Kinh young people agreed more than their ethnic minority counterparts at 83%. Young people's ability to have a say may be affected by the actual opportunities provided and individual characteristics of teachers and students, as well as cultural norms about speaking out. In addition, 85% of respondents agreed that teachers praised them when they did well. This was generally consistent across all groups, with the highest percentage in rural groups (87.7%) and the lowest in the older age group of 22-25 (78.4%).

While few of the students surveyed have been formally disciplined at school, those that had were generally boys (7.9%), with fewer girls at 1.9%. This is in keeping with other school research that shows boys take up more teacher time than girls in terms of discipline problems. There is also some evidence that teachers may focus more on the negative behavior of boys.

The majority of students reported that they try to study hard (90.8%). Interestingly, 73.9% did not agree that the workload was too heavy, with 10% being undecided and 16.2% agreeing it was too heavy. There has been significant discussion within education circles about the increasing stress on students resulting from study pressure. The findings of this survey – with few students reporting a heavy workload – are surprising and seem to be at odds with prior findings<sup>4</sup>. Only 15% of the 14-17 year age group agreed that the work load was too

heavy compared with 25.2% of the older group. Factors influencing this finding may include: young people don't report the workload as too heavy because they perceive a heavy workload as a good foundation for success; reporting the work load as too heavy may reflect a student's academic weakness; the media and parents have overstated the workload issue; and students may feel obliged not to criticize the curriculum and will therefore report an appropriately weighted work load.

It should be noted that only the SAVY respondents who were studying were asked about school workload. As they are aged from 14-25 (Grade 9 or above) the data cannot be applied to work loads in primary and lower secondary grades (between grade 1-8).

The majority of young people who were studying

report that they wanted to go to university (90%). This is in stark contrast to the actual numbers that attend higher education or university or gain a degree at less than 10%<sup>5</sup>. This high expectation might result in many students feeling disappointed about not reaching their goal, as well as creating increased competition to attend university. However high expectations may also drive young people to perform at a high level.

Vocational training research suggests that the expectations and high status afforded to university may impact negatively on young people's willingness to participate in job/vocational training<sup>6</sup>. This survey shows a low level of vocational training at 18.9%. Further exploration about the availability of training compared with demand for vocational training might be useful, particularly tailor-made vocational training courses that provide direct entry into jobs.

A rather high number of young people surveyed (70%) felt that schools provided access to disabled students. This perception seems not to fit the reality, where young disabled students have limited access to education, particularly higher education. This high percentage also reflects young people's sympathetic and accepting attitudes to others with disabilities but does not reflect the capacity of school environments to meet young disabled needs. Issues of inclusivity in education have gained greater prominence and will be of interest to track in future surveys.



1. United Nations in Viet Nam. Millennium Development Goals: Bringing MDGs Closer to the People. Hanoi; 2002 Nov.
2. Government of Viet Nam. 2001-2010 Education Development Strategy. Hanoi; 2001.
3. UNICEF Speaking Out 2000 Op Cit
4. Presentation at Quality of Education Forum, Joint UNESCO and MoET Forum, Hanoi 2003
5. Quyen BT, Nguyet CN, Kim Dung NT, Bhuong TB, Haughton D, Haughton J. Education and Income. In: Haughton D, Haughton J, Phong N. editors. Living Standards During an Economic Boom: The Case of Viet Nam. Hanoi: Statistical Publishing House; 2001. p. 79-94.
6. United Nations Country Team Viet Nam. Challenges to Youth Employment in Viet Nam Hanoi; 2003 Jun. Discussion Paper No. 3.

## Chapter 3

## Work and Employment and Vocational Training

This section explored a range of issues about young people who had worked for pay including age at starting work, type of jobs, the job market, access to job training and job satisfaction. Work for pay was defined as receiving cash for work.

### 3.1. Rates of Work

Over half of all young people surveyed (54.9%) had worked for pay at some time. There is little difference between young people from urban areas (51.8%) and rural areas (55.8%), or between males (57.7%) and females (52.1%). The percentage of young people who had ever worked for pay increased with age, from 32.3% for the youngest group, to 64.7% for the 18-21 age group and 85.7% for the 22-25 age group. Just over one quarter of school/university students reported to be full-time students as well as working for pay at some time (26.4%). Of those at school, 5% reported that they were looking for a job at the time of the survey. Among those who had no current paid job, 9.9% were looking for a job and within that group about

one third (32.2%) did something towards finding a job in the week before SAVY took place.

Of the survey respondents 34.5% currently had a job for which they were paid. Again as expected, there is an increase in percentages by age, with 14% in paid work in the 14-17 age group, increasing to 41.2% in the 18-21 group and 65.5% in the 22-25 age group. Young people were asked at what age they first worked for pay. The mean age for acquiring a paid job is 16.5 years, though rural youth on average start to work earlier than urban counterparts (16.1 years compared to 17.6 years).

While the vast majority of young people under 15 are not in the work force because they are at school, just under 7% of this age group reported to have worked for pay. Of the total sample who had worked for pay, 13.2% had done so by age 15. Twice as many rural youth worked before 15 years (15%) compared to urban (7.3%), with higher percentages of underage workers in ethnic minority groups (21.5%). The reasons for underage work have previously been reported to include poverty, the need to support family, exploitation and the increased opportunities of modernization<sup>1</sup>. The *Labor Code of Viet Nam* states the minimum official working age as 15 years.

Across age groups young people consistently

**TABLE 4 Current Paid Work by Occupation**

Main occupation	Urban-rural residence %		Gender %		Age Groups %			Total Survey %
	City-Town	Rural	Male	Female	14-17	18-21	22-25	
Trained craftsperson or similar	31.9	27.2	26.6	30.3	17.9	31.5	29.8	28.3
Unskilled labor	26.6	27.6	30.2	23.9	38.5	30.6	19.4	27.3
Unskilled agricultural jobs	7.5	32.6	24.7	28.4	38.2	24.2	23.4	26.4
Professional technician	11.3	2.7	3.6	6.3	-	1.9	9.6	4.8
Private service, guard, salesperson	7.1	2.9	3.3	4.6	2.9	3.2	5.0	3.9
Office Staff	9.0	1.2	1.9	4.7	0.2	2.1	5.5	3.2
Mechanic	4.6	3.2	5.9	0.7	0.4	3.3	5.0	3.5
Skilled farmer, forester, fisherman	1.0	2.7	3.4	1.0	1.8	2.8	2.0	2.3



reported that it was difficult to find a job (64.1%). 28.3% were neutral when asked whether it was easy or difficult to enter the job market, with only a small number perceiving it to be easy: around 5% urban and 8.6% in rural areas.

Of the total sample, about 12% reported to be neither working or in school. The figures for male and female are not very much different, with 10.3% for male and 15.4% for female. It is surprising that, while the figure for unmarried young people is 10.1%, 28.4% of married people are neither working nor studying. The reasons may include the difficulties married people have in finding a job and the fact that newly married women in the sample have children and were not working at the time of SAVY.

### 3.2. Types of Employment

Table 4 summarizes the respondents' occupations by age, gender and residence. More than 50% of working youth have a simple job (i.e. non-skilled work in the agricultural or non-agricultural sector). Handicrafts are the next highest category, and that

includes traditional family businesses that attract many young employees. The urban work pattern is significantly different from that of rural. More than 60% of rural youth have a simple job compared to 34.1% of their urban counterparts. Urban youth tend to report occupations that require a higher level of professional skills.

Self-employment accounts for the largest percentage of occupational types (35.3%), followed by small family enterprises (19.9%) and private enterprise (8.7%) (see Table 5). State-run enterprises account for only 6.7% of working youth. It is expected that the number of young people working for state-run enterprises will further decrease when one quarter of state-run enterprises are privatized (a total of 4,000 enterprises) in the near future. It is most likely that the creation of new jobs will occur through private enterprise, small business and joint-venture enterprises.

### 3.3. Job Satisfaction

78.2% of working youth are satisfied with their current job (urban, 81.6%; rural, 77%), with the

**TABLE 5 Current Paid Work by Employment Sector**

Employment Sectors	Urban-rural residence %		Gender %		Age Groups %			Total Survey %
	City-Town	Rural	Male	Female	14-17	18-21	22-25	
Self-employed	26.9	38	31.7	39.4	30.1	34.0	38.7	35.3
Small, family enterprise	20.6	19.6	24.	14.7	27.0	21.2	15.5	19.9
Private enterprise	13.3	7.2	7.6	10.0	8.0	9.8	8.0	8.7
State-run enterprises	8.3	6.2	6.4	7.1	4.4	6.5	7.9	6.7
Government institution, military	7.2	3.0	3.0	5.3		1.9	7.8	4.0
JV with government, co-op, private	4.7	2.6	2.4	4.0	1.2	4.2	3.0	3.2
Communist Party institution,	1.4		0.5	0.1	0.1	0.6	0.2	0.3
Co-operative enterprise	0.9	0.3	0.5	0.4	0.1	0.4	0.6	0.4
Foreign-owned enterprise	4.6	1.4		3.4	0.1	3.0	2.4	2.2
Other joint-venture	3.0	1.4	1.3	2.5	1.8	1.8	1.9	1.8
Other	8.9	20.2	21.1	13.1	27.2	16.6	13.9	17.4
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

**TABLE 6** *Employment Satisfaction Levels and Job Seeking*

Breakdowns		Currently employed (satisfied with current job)	Currently looking for another job	Actively looking for job last week (one week before survey)
Urban-rural residence	City-Town	81.6	16.2	45.1
	Rural	77.0	15.4	42.1
Sex	Male	75.2	15.8	43.9
	Female	81.6	15.4	41.8
Age Group	14-17	73.4	7.2	29.4
	18-21	77.2	22.9	47.2
	22-25	81.1	21.6	44.9
Geographic Region	Red River Delta Region	80.6	18.4	44.3
	North East Region	77.9	13.4	43.2
	North West Region	78.6	10.4	32.6
	North Central Region	69.9	15.8	40.9
	Coast Central Region	73.8	17.0	33.9
	Highland Region	77.3	9.2	54.
	South East Region	80.8	15.1	47.5
	Mekong River Delta Region	78.3	15.8	41.7

highest satisfaction recorded by females (81.6%) compared with males at 75.2%. Even in unskilled agricultural jobs, a majority recorded job satisfaction (73.3%), even though this satisfaction rate is a little lower than the rate for other occupations.

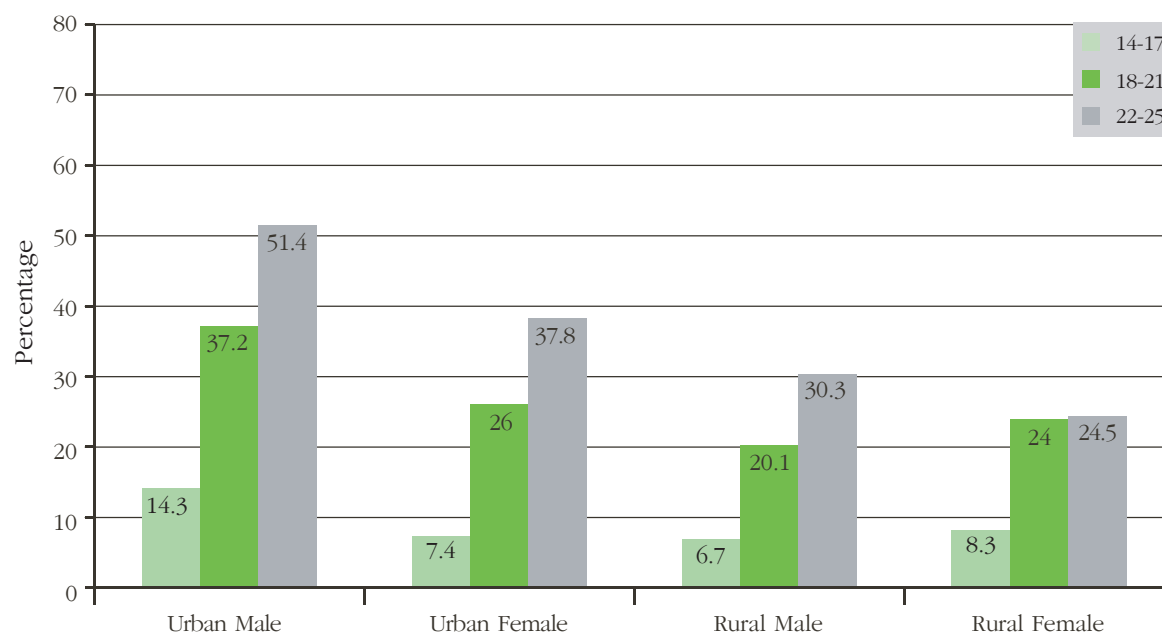
There is not a great deal of difference between regions in relation to job satisfaction. All regions recorded percentages between 70% and 80%, with the highest satisfaction in the Red River and South East Regions (80.8%) and the lowest in the North Central at 69.9%. These are further elaborated in Table 6.

22.7% of working respondents reported that they were looking for another job, though only 7.2% of the youngest group was looking. The overall percentage is very similar to the percentage of youth who were not satisfied with their current job (21.8%). However less than half of those who were looking for a job (42.9%) had actively looked for work the week before the survey took place. Those

most actively seeking work were young men aged 14-17 (74.9%), followed by 22-25 year old males at 58.8%.

### 3.4. Vocational Training

18.9% of respondents had been involved in some form of job training, with 13.3% of the total sample having completed such training and 5.6% being trained at the time of the survey. Of those who had received job training, 67.1% found a job in the area they were trained for, which is a relatively high figure. However, about a third (32.9%) could not find the job they were trained for. Factors affecting the low percentage of young people entering vocational training include limited training opportunities and the cost of training, as well as a perception that vocational or job training is less economically rewarding and less prestigious than academic training.

**GRAPH 6 Access to Vocational and Job Training**

Urban youth have more access to vocational training, at 26.6% compared to 16.5% in rural areas. A large disparity can be seen in vocational training opportunities for young people from ethnic minorities (5.2%) compared with their Kinh counterparts (21.2%) (see Graph 6).

### 3.5. Work as a Priority for Youth

In questions relating to future aspirations (see Chapter 10) young people identified work as the

highest priority (49.6%). It is worth noting that the figures are not much different between age groups, male and female, or rural and urban locations. This demonstrates that many young people are concerned with serious issues despite being at a transitional period in their lives. When invited to make recommendations to government about what could improve young people's lives, 40.5% suggested that increased opportunities for work should be the number one priority for the government in terms of improving the lives of young people.



1. Khanh VD, Thu Thuy VT, Koan BK, Phong LH, Phuong NQ. Labor and Employment. In: Haughton D, Haughton J, Phong N, editors. *Living Standards During an Economic Boom: The Case of Viet Nam*. Hanoi: Statistical Publishing House; 2001. p. 141-70.

## Chapter 4

## Friendships, Dating, Sexuality and Reproductive Health

This rather extensive chapter deals with a number of topics relating to relationships, reproductive health, and sexuality. It considers young people's awareness and knowledge about reproductive health, family planning and pregnancy as well their attitudes and behaviours to issues of pre marital sex, contraception, sex work, and homosexuality. This chapter also reports on young women's experiences of pregnancy including use of prenatal services and finally presents data on abortion.

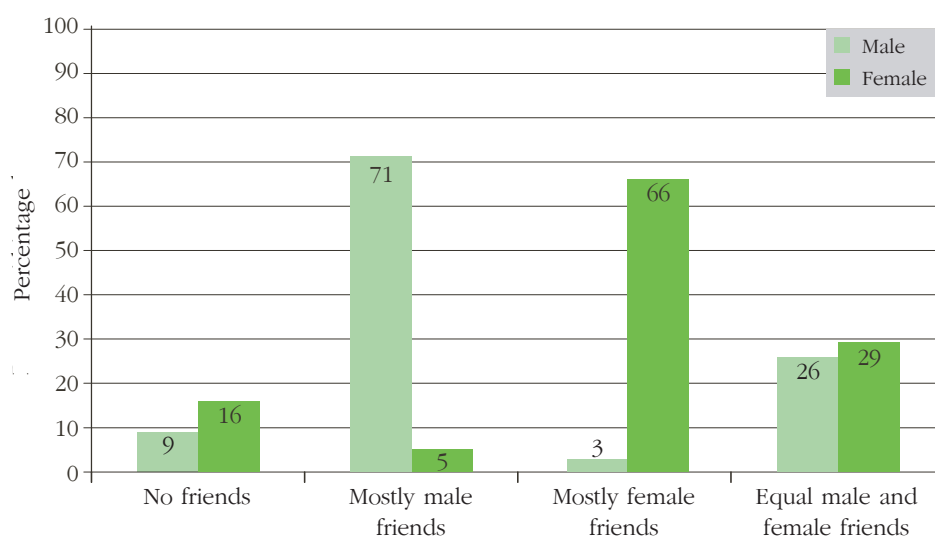
### 4.1. Friendship and Peer Groups

Young people were asked about whether they have a group of friends with whom they often keep company, and the gender composition of their friendship groups. The majority of the respondents (88%) report that they do have a group of friends with whom they often meet. 12% of the respondents reported not having a group of friends. Within that figure there is a rather marked gender difference, with 9% of males and 16% of females

reporting that they have no group of friends. While living in isolation may account for some of this percentage for women, cultural expectations about women staying home, caring for their family and working hard mean that they have limited time for socializing and maintaining friendships. Among those who have friends, 75% report that they have a mixed peer group, made up of both males and females. There is almost no gender difference in this regard (76% for males and 74% for females). However, peer groups of boys tend to consist of mostly boys, and peer groups of girls tend to consist mostly of girls. About a quarter of boys 26% and 29% of girls have groups of friends consisting of about equal numbers of boys and girls. Around 5% of girls in the sample report that most of their friends are boys, while only 2-3% of boys report that most of their friends are girls (see Graph 7).

In many countries, the majority of young people have peers of the same sex, but this pattern appears even stronger in Viet Nam, especially for the older age groups of 18-25 years. Research with parents in Hanoi suggests that some parents prefer same sex peer groups, and discourage mixed peer groups in an effort to avoid the attraction between young people of the opposite sex that often occurs during puberty<sup>1</sup>. Such parental attitudes and perceptions may create barriers to open communication between young men and women.

**Graph 7 Gender Composition of Peer Groups**



## 4.2. Puberty

A central developmental hallmark of adolescence is the onset of puberty, a time when the body physically develops and matures. With these physical changes often come many emotional and psychosocial changes, which can pose challenges for young people and parents alike. A significant milestone for young women is commonly seen as menarche, or getting their first period, and for young men the first nocturnal emission, or wet dream. Young people were asked about the age at which they first had a period or wet dream.

As shown in SAVY the average age of the first period for young women was 14.5 years, and the average age for young men's wet dreams was 15.6 years. Women tend to have an earlier onset of puberty than men. For example, while only 3.3% of young men had experienced a wet dream by age 13, 17.3% of young women at that age had experienced their first period. By age 15, 79% of young women had experienced menarche, and 50% of young men had experienced a wet dream.

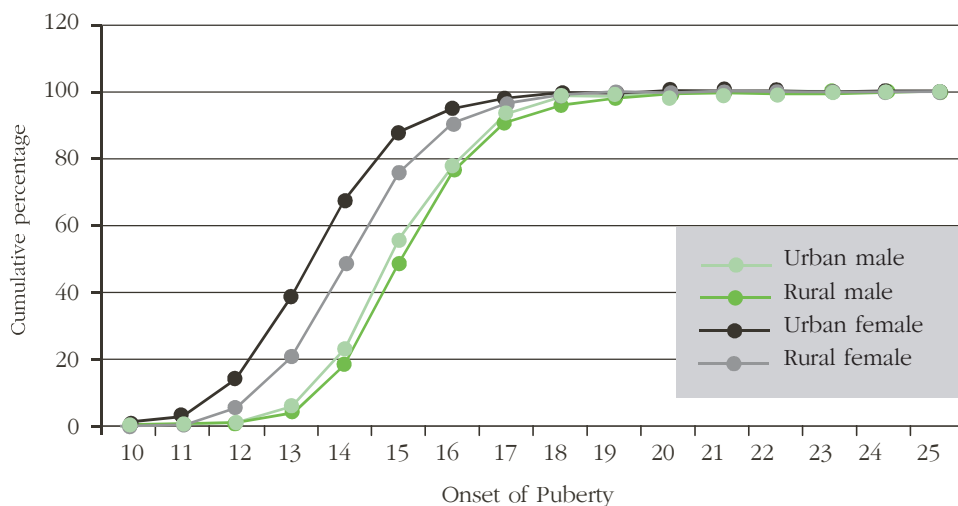
There is little difference between urban and rural men in terms of the onset of puberty. The average age of the first wet dream for urban men is 15.4 years; for rural men it is 15.7 years. However, there is a marked difference between urban and rural women in the timing of the first period. For urban women, the average age of menarche is 14 years. This is significantly earlier than for the rural young

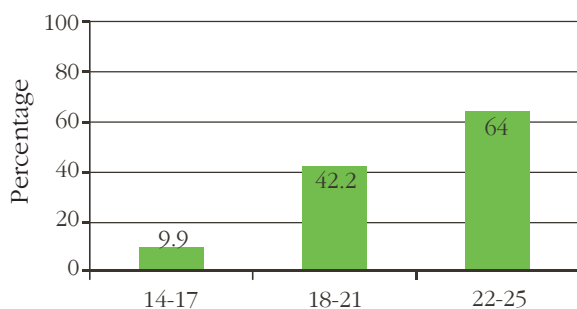
women at 14.6 (see Graph 8). The onset of puberty is related to nutrition status among other factors. The observable differences between urban and rural women, and the lack of difference between urban and rural men, suggest that women in rural areas are possibly in a disadvantageous position in terms of nutrition, independent of the effects of sex differentials. This result is somewhat different from the findings of the recent National Health Survey 2002 in which there is no record of females being in a disadvantageous position in terms of nutritional status<sup>2</sup>. A similar finding is observed for the timing of puberty for ethnic minority and Kinh men and women, with almost no difference between ethnic and Kinh men and considerable differences between ethnic and Kinh women. On average, ethnic women experienced their first period at age 14.9, while Kinh women experienced it at age 14.4.

Although the vast majority of young people are not sexually active at the onset of puberty, the psychosocial effects of these physical changes can be a real challenge, and being un-prepared and ill-informed about such changes may result in these normal and common adolescents' experiences being more traumatic than necessary. In some cultures, such milestones are celebrated as important transitions and joyful events in a young person's life.

The above analysis highlights the need for the provision of information for boys and girls in the early teenage years about changes during puberty

**GRAPH 8 Age of Onset of Puberty**



**GRAPH 9** *Percentage of Boyfriend/Girlfriend Relationships*

and to prepare them well for these imminent experiences. Information about puberty and related changes can be introduced early in junior high school and at an appropriately young age by parents at home.

### 4.3. Boyfriends and Girlfriends

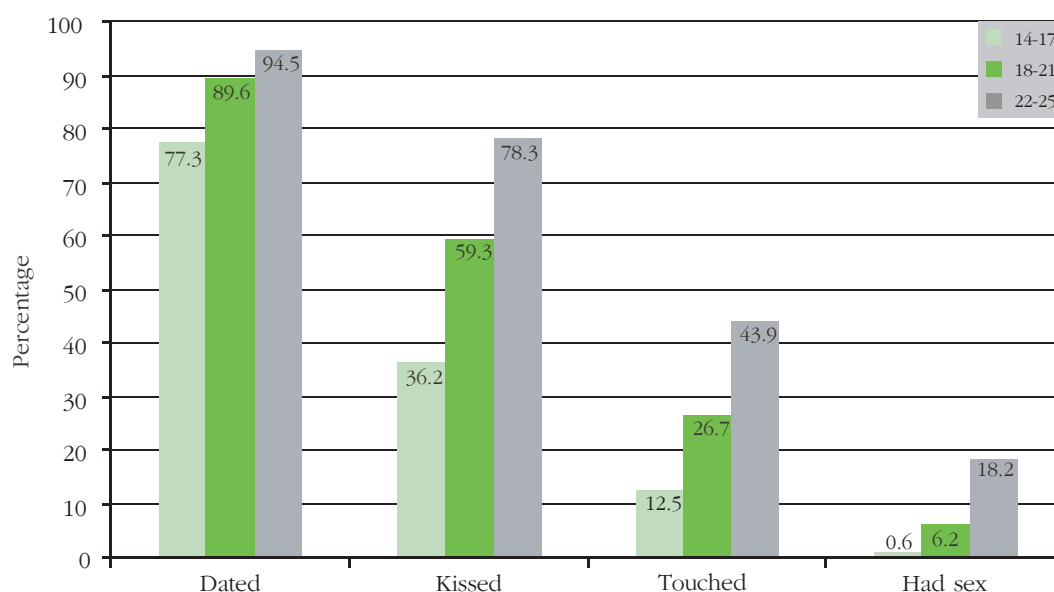
Young people were also asked a series of questions about their attitudes, perceptions and behaviors relating to having a boyfriend or girlfriend: dating, kissing and sexual relationships. The first question in this series that was posed to young single people

was: 'Have you ever had a boyfriend or girlfriend?'

Of the total sample of unmarried respondents, 28% reported having had a boy friend or girlfriend. As illustrated in Graph 9, a small percentage (9.9%) of 14-17 year-olds reported that they had previously had a boyfriend or girlfriend. There was a substantial increase in the 18-21 age group (42.2%) and the 22-25 age group (64%). Having a boyfriend or girlfriend was more likely in urban areas (36.8%) compared to rural areas (25%). Interestingly, about 35% of those in the 22-25 age group reported never having had a boyfriend or girlfriend.

Within boyfriend and girlfriend relationships, certain types of behavior appear to increase with age, in both the percentage of those who engage in that behavior and in the degree of intimacy. Graph 10 shows the prevalence of a range of behaviors in the three different age categories.

The majority of those who reported having had a boyfriend or girlfriend also reported that they had dated, with figures increasing according to the three age groups: 77.3%, 90% and 94.5%. Of those who had dated, kissing was the least likely to take place in younger groups (36.2%), again increasing with age to 59.3% in the 18-21 age group and 78.1% in the 22-25 age group. A smaller percentage reported

**GRAPH 10** *Dating and Relationship Experiences by Age Group*



more intimate behavior, such as touching private parts (12.5% of the 14-17 group, increasing to 26.7% and 43.9% of the older groups).

## 4.4. Sexual Relationships

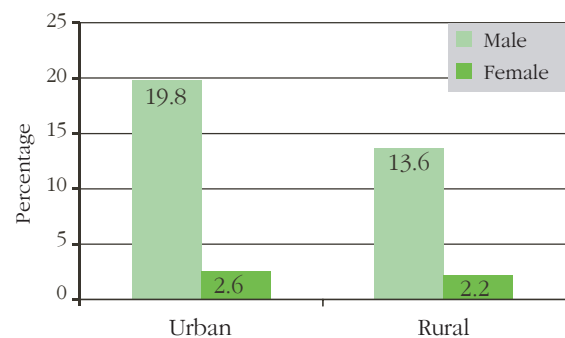
### 4.4.1. Single Young People and Sexual Relationships

Sexual activity is rare among young people aged 14-17. Out of the 3,213 respondents of this group, only eight (seven boys and one girl) in urban areas and 12 (nine boys and three girls) in rural areas said they were sexually active. These figures may be under-reported due to the sensitivity of the question. Nevertheless, the rarity of sexual events among people of this age group is perhaps the reality. These people are very young (one person was aged 14, one was aged 15, 8 were aged 16, and 10 were aged 17). Despite the small number of sexually active people in this age group, it is worth knowing that they had their first sexual encounters when they were very young. One boy had sex when he was only 14 years old, six had sex when they were 15, seven had sex when they were 16, and five had sex when they were 17. Although it is rare, the existence of sexual encounters in people in this age group suggests that parents and schools should pay particular attention to the sexual education of people in this age group to assist them in skills to avoid risky behaviors.

Since the number of sexually active people in the age group 14-17 is so small, in the subsequent analysis they are excluded. Nevertheless, one should keep in mind that much of what is discussed below may very well also be applied to this youngest age group.

81.1% of males and 62.8% of females in the 18-25 year age group reported themselves to be single. Among people aged 18-25 who responded to the question "Have you ever had sex with anybody?" 9.6% answered in the affirmative. The proportion of those who had ever had sex is higher for boys than for girls, and higher in urban than in rural areas (see Graph 11). Previous research comparing other Asian<sup>3</sup> (and some Western<sup>4</sup>) countries suggests low rates of sexual experimentation and activity in this adolescent group, particularly among girls.

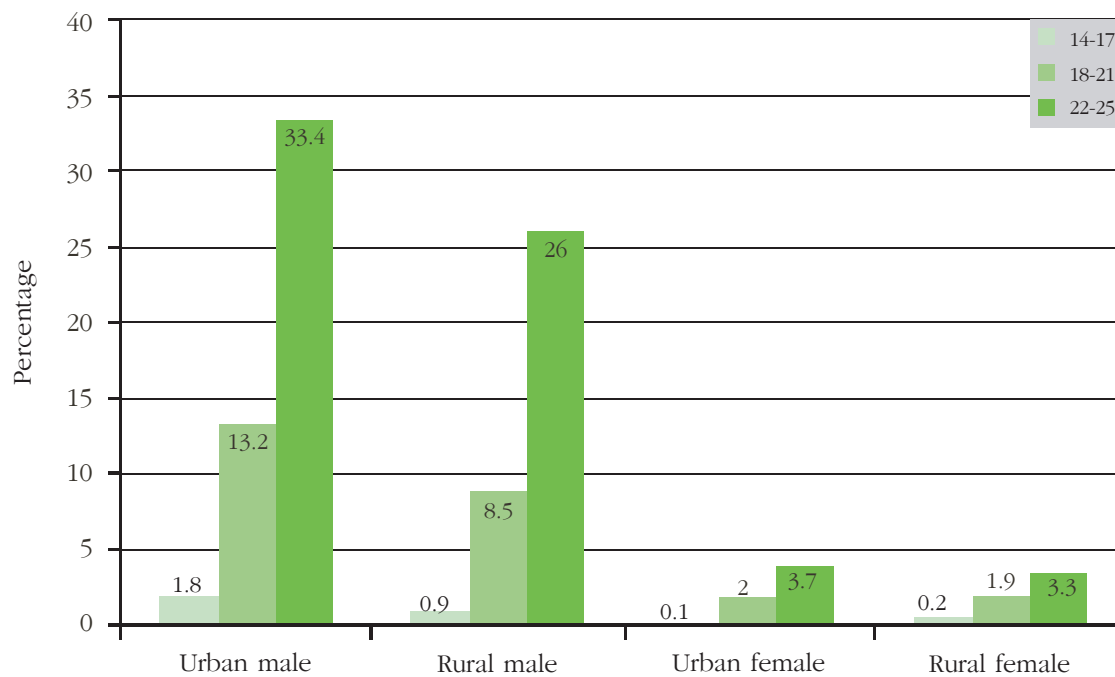
**GRAPH 11** *Proportion of People Aged 18-25 Who Have Ever Had Sex*



Consistent with the literature for other Asian countries<sup>5</sup>, the results of this survey indicate that single young people who reported that they have been sexually active were predominantly male (15.4% compared to 2.3% of females). The figures for premarital sex have therefore been delineated by gender, location and age group to better highlight the similarities, differences and trends for between- and within-group comparisons of young people's premarital sexual experiences.

Of interest to public health planners and parents alike is the finding that one in three single urban males (33.4%) aged 22-25 reported premarital sex as compared to only 3.7% of their female counterparts. This pattern is evident again in rural males aged 22-25, with 26% reporting premarital sex compared to 3.3% for their female counterparts. Factors influencing this gender differential may include under-reporting by young women because of cultural beliefs and the stigma attached to premarital sex, young men frequenting sex workers, and younger men having sex with older women.

Such differences in gender reporting of premarital sex are consistent with results from studies of adolescents across Southeast Asia. In one study which compared youth from 14 countries worldwide<sup>6</sup>, never-married young women aged 15-19 in Thailand and the Philippines reported extremely low levels of premarital sex (1-3%), while young men of the same age were slightly more likely to be sexually active (12% in the Philippines; 27% of young men in Thailand). However, these rates are extremely low for both genders compared with many countries in sub-Saharan Africa, Latin

**GRAPH 12** *Percentage of Premarital Sex by Age and Sex*

America and the Caribbean, Great Britain, and the United States.

#### 4.4.2. Sexual Partners

Of those single young people who were sexually active, the majority (71.9%) reported that they had their first sexual experience with their girlfriend or boyfriend, 10% with a friend, and 9.1% with a sex worker. The vast majority (85%) also reported to have only had one partner in the past 12 months. Young women reported having had their first sexual experience with a male who was older by a few years.

Among the single group who were sexually active, only six out of 317 male respondents reported being offered money for sex.

#### 4.4.3. Venue of First Sexual Experience

The majority of married people (92%) reported having their first sexual experience in their own or their partner's home. However a different pattern emerges for unmarried young people, with only 28% having their first sex in their own or their partner's home. The most commonly reported

venue for unmarried men's first sex was a hotel (39.4%), and 8% reported their first sex in a park. Single urban young men reported first sex in a hotel more often than their rural counterparts. Sexually active single males in the 18-21 year old group were somewhat more likely to be in this category, with over 50% of males reporting their first sexual experience to have taken place in a hotel. Very few sexually active unmarried young women reported their first sex as having taken place in a hotel.

This finding indicates that just fewer than 30% of sexually active single young people had their first sexual experience in environments known to them (homes) and in places that are relatively safe. Compared with married people, generally it is not easy for single young people to have sex in their homes. Many of them perhaps chose not to have sex there. This may be due to privacy and/or secrecy issues. Many young people may want to avoid being caught by their parents, or they may feel discomfort at taking part in what is perceived as culturally inappropriate behavior in the home environment. Another factor could be that places like hotels or parks provide easy venues for young people to meet their sexual partners.



While this group of single sexually active young people (mainly men) may be small within the overall sample, they are a significant high-risk group for HIV. Understanding more about the nature and risks associated with these early male sexual experiences will help to design appropriate programmes and interventions. SAVY provides evidence suggesting that targeting hotel sites for interventions and promotion of safe sexual behaviors will help to reach a significant number of young men at their first sexual encounter.

#### 4.4.4. Age of First Sexual Experience

The age for first sexual experience of young people in the sample is relatively late compared to the situation observed in Western countries and some other Asian countries<sup>7</sup>. The average age at first sexual encounter of the respondents in the sample is 19.6 years, similar for young men (20.0 years) and women (19.4 years). Ethnic minorities reported sexual initiation at 18.6 years, approximately one year earlier than the Kinh majority.

The majority of those young people who have had sex report that they continued to have sex after the first time. The continuation rate was 92% for the married respondents and lower for the single respondents (70%). For the 30% who do not continue to have sex, they may have changed their minds, or reconsidered their decision and therefore delayed, or stopped further sexual activity. The reasonably high figure of 70% of single young people continuing to have sex after the first time suggests that perhaps the decision to have sex is well considered and not 'spur-of-the-moment'.

#### 4.4.5. Frequency of Sexual Activity

All sexually active young people were asked about the frequency of sex during the last month and this was reported to be on average five times, with some variation between sub-groups. A very striking difference, and one to be expected, is the much higher rate of sexual activity by the married respondents, at six times per month, compared to that of the single sexually active group, at 1.7. Of the total sample of sexually active young people, urban males 22-25 years reported 3.8 times, with their rural counterparts reporting six times. Urban females reported 4.4 times, while their rural

counterparts reported 5.1 times. This difference could likely be linked to the fact that a greater percentage of young people living in rural areas are married, compared to their urban counterparts. Ethnic minority young people reported slightly higher frequencies, with males reporting 7.3 times and females reporting 6.1 times in the prior month.

#### 4.4.6. Sex with Commercial Sex Workers

Very few of the sexually active men in the sample reported to have had sex with a commercial sex worker (5.3%). However only 1% of the married men reported sex with a sex worker compared to 21.5% of the sexually active single young men who responded "yes" to the question: "Have you ever had sex with a commercial sex worker?"

No women reported having had sex with a sex worker. It should be noted that interviewers may not have asked young women this question, though they were instructed to, following the commonly held assumption in Viet Nam that all sex workers are female and that a male commercial sex worker service does not exist for women (or for men).

More single sexually active urban males access sex workers than their rural counterparts, as is clearly demonstrated in Graph 13. The reasons for the differences in accessing the services of sex workers between urban and rural areas could include increased availability and access to commercial sex workers in urban areas, the greater economic resources of young urban men, and cultural differences in urban and rural men's sexual

**GRAPH 13 Sexually Active Single Men Who Have Had Sex with a Sex Worker**



behaviors. Interestingly, the percentage of urban young men between 14-17 using sex workers is high (34.4%), suggesting that young men may be involved with sex workers as part of their initiation into adulthood or as experimentation during adolescence. It should be noted, however, that there are very few urban young men in this age group who are sexually active (1.8%, or n=32). Caution is required in considering these results.

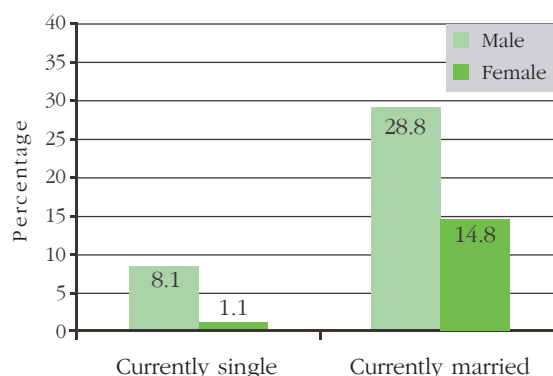
Reported usage of condoms by men with sex workers was very high (93.2%), with urban men reporting closer to 100% and rural men at around 90%. While only 1% of married men reported having sex with a sex worker (n=15) their rate of condom use is lower at 66.1%, compared with 98.1% of the single men reporting to use a condom when having sex with sex workers.

Attitudes to condom use were generally negative; for example, 70% of all respondents reported that condoms reduced pleasure and half of those surveyed felt that people who carry condoms might have improper relations. In addition, 30.2% of respondents said that condoms were only for 'prostitutes and unfaithful people'. Of interest, and with possible implications for future condom social marketing approaches, respondents were convinced about the practical effectiveness of condoms: 98.5% agreed that condoms could stop pregnancy and 97% agreed that they could prevent HIV and STIs if used properly. It should be noted that previous studies have recorded much lower levels of condom usage<sup>8</sup>.

#### 4.5. Premarital Sex among the Married

Of the total sample, 7.6% reported premarital sex, with a disparity between males (11.1%) and females (4%). Premarital sex in some ethnic minority groups is more common, with 39.8% of males and 26.1% of females reporting premarital sex, possibly indicating that premarital sex is a more acceptable behavior in these groups. The married people in the sample were also asked about premarital sex; 22.2% of married respondents reported to have engaged in premarital sex; 28.8% of men and 14.8% of women. This figure was far higher than the rate of premarital sex among singles (males at 8.1% and females at 1.1%). While this may be age-related, the

**GRAPH 14** *Percentage of Those Reporting Premarital Sex*



very large discrepancy suggests that after marriage it is easier and more culturally acceptable to acknowledge that premarital sex did occur than it is to report its occurrence while single. 19.2% of the married sample reported that they had premarital sex with their current spouse, with only 6% reporting sex with someone other than their spouse before marriage.

The rates of premarital sex reported by those already married may provide a closer estimate of the numbers of young people engaging in premarital sex. In this respect, the information can be very useful in planning for appropriate and adequate reproductive health services, IEC campaigns, and prevention and treatment services for both married and unmarried young people.

The very high numbers of young married people who report only having had premarital sex with their spouse (92%) also shows a pattern of sexual activity within a committed relationship, and this signals the continuance of rather strong moral values about love. At the same time, it indicates some departure from traditional norms, according to which one should not have sex before marriage, and this is especially applicable to women. It is also a positive finding for public health professionals, as young people tend not to have multiple partners prior to marriage. However, what remains a challenge is to better understand the patterns of behavior of the 15% of men, both Kinh and ethnic minorities, who do report having sex with someone other than their spouse prior to marriage. This figure is much lower for women (1%).

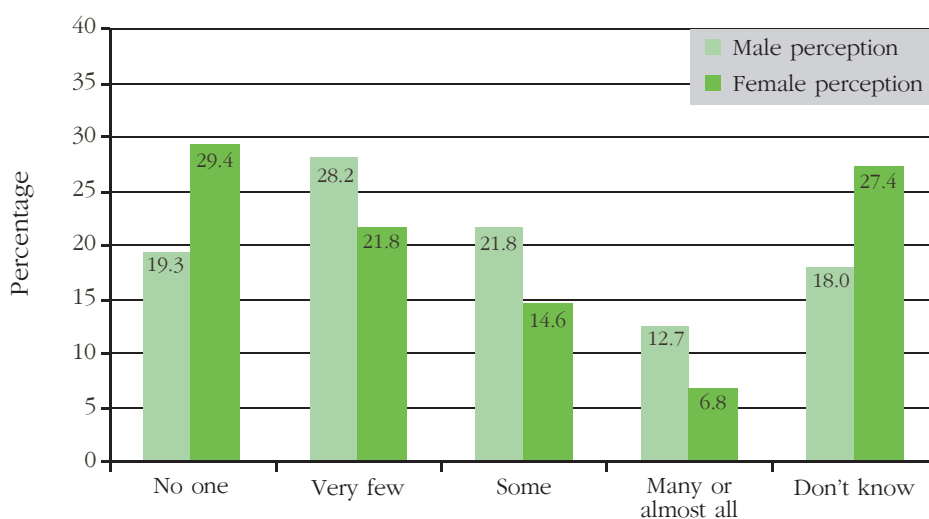
#### 4.6. Perceptions of the Prevalence of Premarital Sex

To gauge young people's perceptions of both the prevalence of premarital sex in the locality in which they lived and their attitudes to premarital sex, SAVY asked young people the question: "How many young males/females have experienced premarital sexual relationships within your neighborhood?" About one-fifth (22.5%) of all respondents reported that there was no premarital sexual activity in their community, with a higher

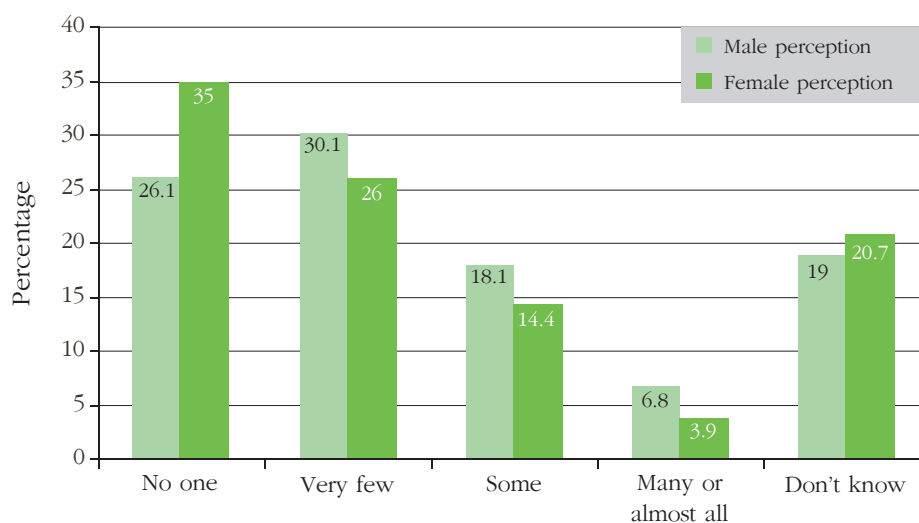
percentage of females reporting a complete absence of premarital sex.

Graphs 15 and 16 compare young men and young women's perceptions about the prevalence of premarital sexual activity within their community. 29.4% of females said there were no young men involved in premarital sex. Only 19.3% of young men, however, shared this perception. About one-fifth (21%) of young women reported that there were 'very few' sexually active young men within the local community, while 28% young men perceived there were very few. 6.8% of young

**GRAPH 15** *Perceptions about Young Men's Premarital Sexual Activity in Locality*



**GRAPH 16** *Perceptions about Young Women's Premarital Sexual Activity in Locality*



women perceived that many or almost all of the local young men were sexually active with 12.7% of the young men themselves perceiving this to be the case. As clearly indicated in the two graphs, both young women and young men perceived young women to be less involved in premarital sex than young men. A minimal difference in the perceptions of married and unmarried young people was noted.

Previous studies in other countries found that young people tend to overestimate sexual activity and other high-risk behaviors in the population, reporting far higher levels than official survey figures show. One reason for this could be the well-publicized and shared myths about a small number of promiscuous local youth that are passed onto young people, who then generalize these specific cases to the whole population<sup>9</sup>. Articles or stories presented by mass media could be misleading and make young people believe that this is the general situation among youth.

Misconceptions and the re-telling of myths can inadvertently put pressure on young people in the way that they imply that young people are involved in certain behaviors, when in fact they are not, or encourage them to conform to behavior that is perceived to be common, when in fact it is not. Comments like ‘everyone has sex’ or ‘everyone gets drunk’ are examples of perceptions not supported by SAVY research. The media, plus alarmist adult attitudes, can contribute to promoting these myths. It is important that misinformation be challenged by evidence. Sound education programs – for young people, parents and policy makers – that provide accurate information about the real levels of sexual activity will be useful in affirming the choices of those young people who delay sexual experience.

#### 4.7. Views about Premarital Sex

Young people’s responses to questions about premarital sex indicate that generally they are not accepting of the practice. Young men, however, have more positive or accepting attitudes toward premarital sex than young women. Small attitudinal shifts can be seen depending on the circumstances under which premarital sex may occur, with young women more accepting of the practice if the couple is to be married and if pregnancy can be avoided.

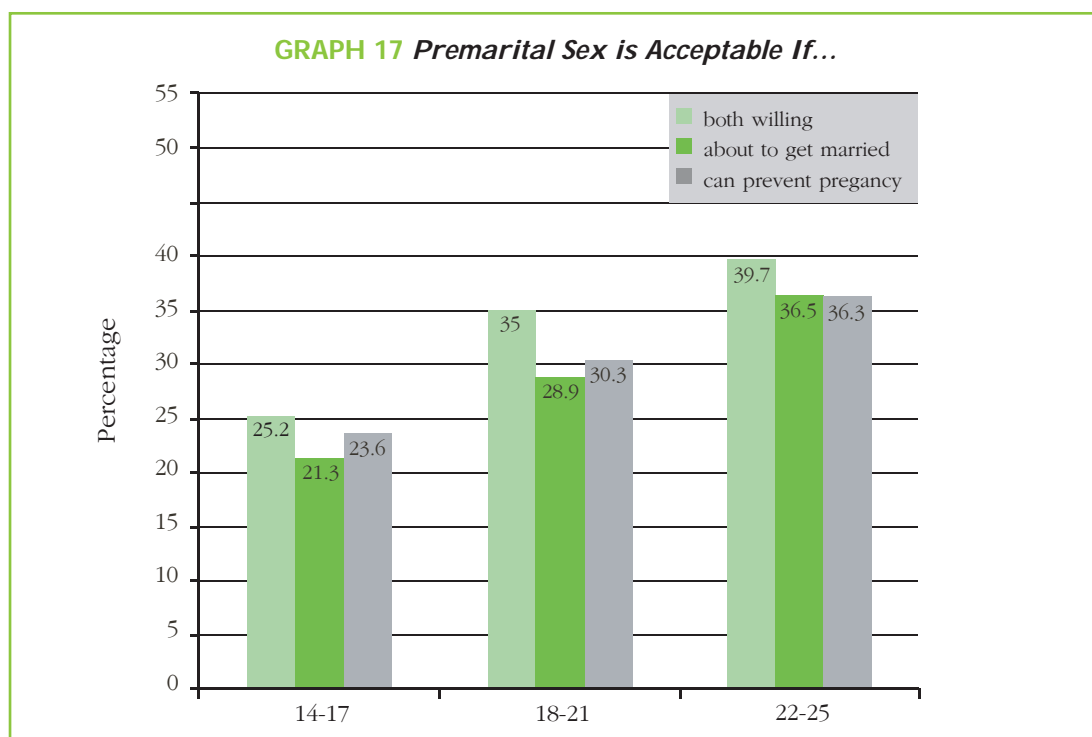
For example, when asked if premarital sex is acceptable if both participants are willing, 41% of males agreed with only 22% females agreeing. While similar numbers of boys disagreed that premarital sex is acceptable if both participants are willing (42.7%), many more girls disagreed (64.4%).

Similar results were reported for the question: Is premarital sex acceptable if the two participants love each other? While 32.5% of males agreed, less than half as many females agreed (14.7%). There appears to be slightly more acceptance of premarital sex if the couple plan to marry (37% males and 17.4% females). This could be explained by more liberal thinking about premarital sex or changing values about virgin. However, more qualitative research is required to better understand the factors influencing such views.

It is worth noting that slightly higher levels of acceptance were reported to the question of whether premarital sex was acceptable if the woman could prevent pregnancy. 37% of males and 20.2% of females agreed, while 42.7% of males and 63.2% of females disagreed. This may indicate that acceptance of premarital sex is not just an issue of morals but may also be linked to possible outcomes and negative consequences, including pregnancy for young women. This view may also indicate young people’s sense of responsibility or more attention being paid to safer sex.

Notably, younger adolescents (14-17 year olds) were far less likely to accept premarital sex than their older counterparts. This is not surprising, given the prevalence of strong propaganda messages about virginity, saying ‘no’ to sex, and the portrayal of premarital sex as undesirable and deviant. Such attitudes may be protective for young people generally. However, for those young people who do transgress from these strongly-held norms, the stigma and enforced secrecy can lead to severe consequences, including not only risks of pregnancy and STI/HIV, but also of family conflict, ruined reputations, damaged youth-parent relationships, decreased self-esteem and premature parenthood<sup>10</sup>.

Internationally, youth programs have moved towards an encouragement of delaying experimentation and initiation of “adult behaviors” but also of acceptance that some young people will experiment<sup>11</sup>. Importantly, research indicates that



comprehensive sexual education, aimed at delaying sexual initiation, has a positive influence on reproductive health knowledge and attitudes<sup>12</sup>. Such programs provide a supportive and enabling environment by delivering both information and skills to equip young people to make safer decisions and choices. This includes services, and sometimes treatment, to deal with inevitable consequences and the “mistakes of youth”.

In relation to these attitudinal questions about premarital sex, approximately 20% on average gave an unsure response, a percentage that is higher than for most other questions. This may mean that these respondents were wavering, or had not really considered the issues and therefore had no opinion. But it may also be the case that the conventions against open discussion of sexual and reproductive issues meant that some young people were too embarrassed to share this information.

#### 4.8. Views about Sex Work

Young people were presented with a range of statements about sex work. While they generally viewed sex work negatively, responses indicate an increasing degree of tolerance with age. Results also indicate that acceptance and tolerance of sex work

depends on the circumstance and nature of the sex work; not all sex work is viewed in the same way.

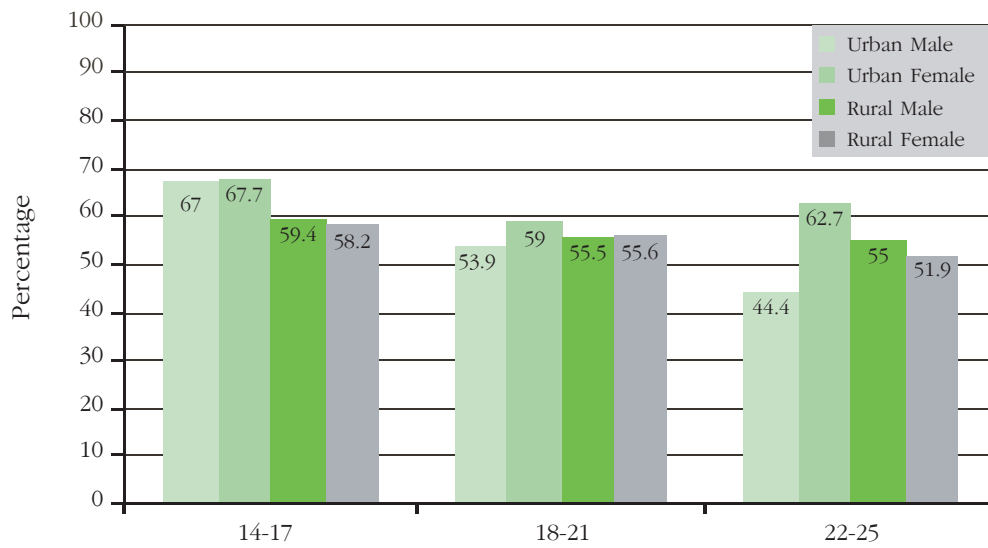
When faced with the statement “commercial sex is immoral”, 57.5% agreed, with no gender differences. More urban younger respondents aged 14-17 were disapproving of sex work, at 67%. Urban older males (22-25) and ethnic minority young women were least likely to agree that sex work was immoral, at 44.4% and 48.4% respectively. Faced with the statement “commercial sex is bad but some must do it due to their circumstances”, 43.4% of the sample agreed. Urban men aged 18-21 years agreed at the highest level (58%), while ethnic minority respondents (30.7%) and rural 14-17 year olds (38%) were least likely to agree. Graphs 18, 19 and 20 show the differing levels of response to sex work questions from different sub-groups of young people.

Further, the statement, ‘whether commercial sex is bad or not depends on each person’s perception’ gained agreement by 38.7% of all respondents. This percentage is interesting, given some of the strong messages linking sex work and social evils that have been communicated through government IEC campaigns<sup>13</sup>.

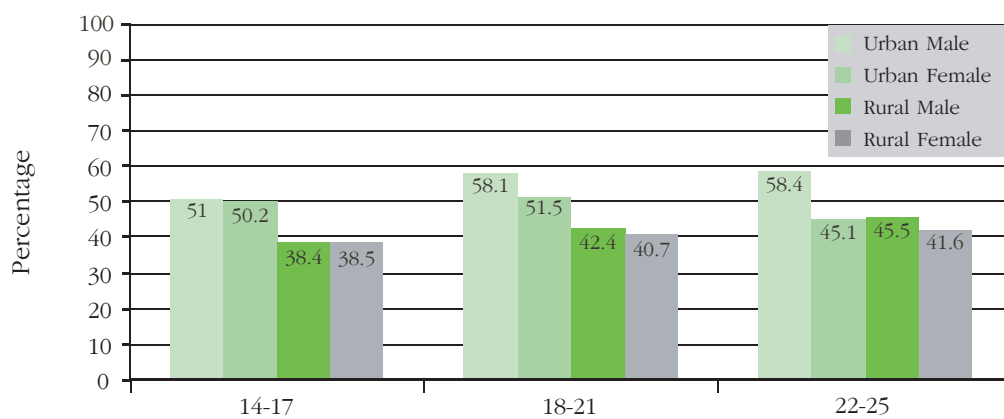
This increasing level of agreement with the



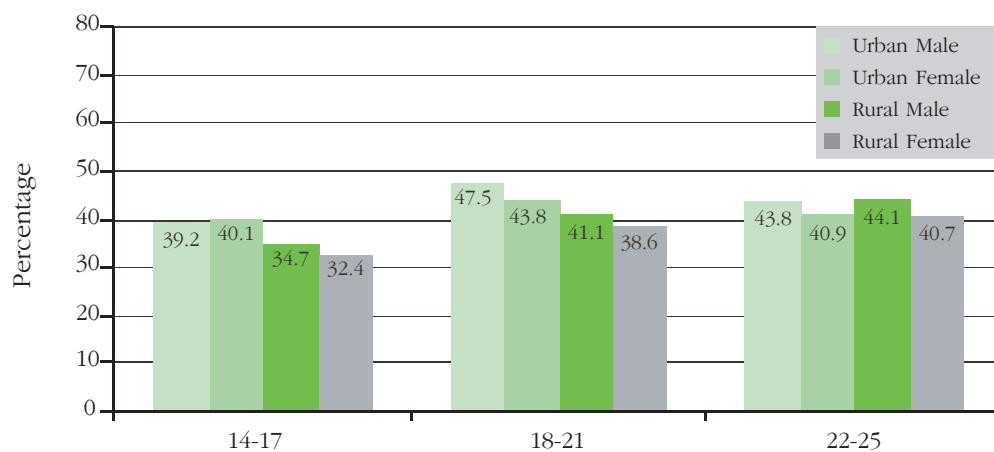
**GRAPH 18** *Commercial Sex Work is Immoral*



**GRAPH 19** *Commercial Sex Work is Bad, but Some Must Do It Due to Their Circumstances*



**GRAPH 20** *Whether Commercial Sex Work is Bad or Not Depends on Each Person's Perception*



statements (or lack of disagreement) indicates an understanding of some of the more complex and underlying factors that result in people's involvement in sex work, and further recognizes that different views and attitudes about sex work exist within this society.

#### 4.9. Awareness of and Attitudes to Homosexuality

Just over 40% of the sample reported that they did not know about homosexuality. The question did not explore the extent of knowledge, but was purely an awareness question. Of the 60% who did know about homosexuality, a very significant 80.2% said they would not accept a homosexual as a friend. Graph 21 illustrates attitudes and acceptance of homosexuality, and highlights some differences between Kinh and ethnic minority young people on this issue. Awareness of homosexuality was lower in ethnic minority groups, at 39% compared to 60% of Kinh youths. However, young people from ethnic minority areas were more likely to accept a homosexual as a friend, and, in fact, 7% reported that they did have a homosexual friend compared to 4.5% of their Kinh counterparts.

The data indicate that while there is a moderate awareness of homosexuality, there is

very little acceptance of it. This poses future potential problems, not only of discrimination, but also of a lack of attention to what is potentially an emerging 'at risk' group that may possibly contract and spread HIV/AIDS. Unprotected male-to-male sexual intercourse is the most potent method of HIV/AIDS transmission<sup>14</sup> and studies conducted in the USA, Thailand, the Philippines, and Australia highlights the vulnerability of this group to HIV/AIDS infection. Future public health campaigns should focus on mitigating stigma and discrimination against this group, not only in terms of human rights but also in order for public health messages, such as condom use, to reach those most at risk.

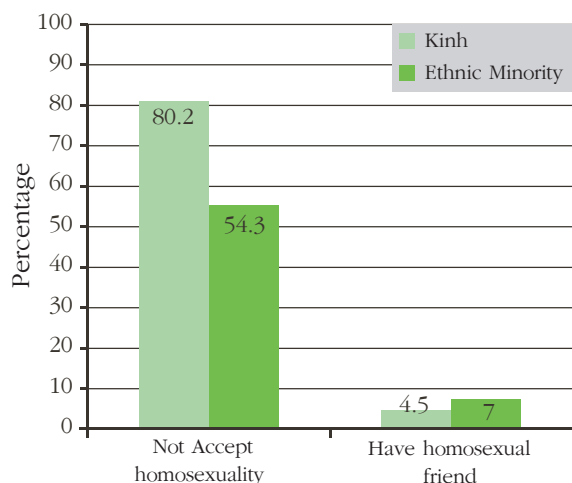
#### 4.10. Experiences of Pregnancy

Of the total sample of women in the survey, 19.4% had been pregnant at some time. Among sexually active women, 88.3% reported to have been pregnant at some time. It should be noted that sexually active women account for only 22% of the total number of women in the sample. Most of these pregnancies (98.4%) occurred in married women in the sample. Higher percentages of pregnancies were reported in rural areas. Among sexually active women, 84.4% of women in urban areas reported to have been pregnant compared to 89.3% of rural women. Predictably, sexually active women in the oldest age group, 22-25 years old, were the most likely to have been pregnant, with 87.4% in urban areas and 93% in rural areas having ever been pregnant. The corresponding figures for the 18-21 age group are urban 78.3% and 83.8% rural. For the 14-17 group 62.6% (urban) and 71.0% in rural.

Of the forty one unmarried respondents that were sexually active, eleven (26.8%) reported to have been pregnant. While these actual numbers are low the fact that about 1 in 4 have been pregnant raises issues about access to contraception, knowledge about pregnancy, negotiation skills around safe sex.

Of all of the young women who had been pregnant, 85% reported having given birth. The average age of first birth is 20.4 years, with 21

**GRAPH 21 Attitudes and Acceptance of Homosexuality**



**TABLE 7 Age at First Birth (%)**

Age at First birth	Urban (%)	Rural (%)	Total (%)
16	3.0	1.0	1.3
17	3.1	5.1	4.8
18	7.0	9.7	9.3
19	12.1	18.8	17.8
20	15.0	22.9	21.6
21	18.2	15.6	16.0
22	16.8	14.9	15.3
23	10.6	5.7	6.5
24	8.5	4.4	5.0
25	5.7	1.7	2.4
25	5.7	1.7	2.4

years for urban females and 20.3 years for rural women. It is a little earlier (19.4 years) for ethnic minority women. Table 7 shows that, of the young women who had given birth, 25.2% of urban young women and 34.6% of rural young women had done so before the age of 20. It should be remembered that less than half of the women in the SAVY sample have given birth before age 25 and therefore the comparisons with other data will certainly show the median age for first birth in SAVY to be lower than surveys that include women aged 15-49. Such surveys indicate median age of first birth at around 23 years of age<sup>15</sup>.

#### 4.11. Preventive Services and Problems During Pregnancy

The majority of young women reported no problems during their most recent pregnancy. However 21.7% reported some problems, with more problems for rural women (22.8%) compared to urban (16%). A very high percentage of women reported that they had a check up during their first pregnancy (83.3%), with just fewer than 90% in urban areas and 82% in rural areas, dropping to 64.4% for young women from ethnic minority areas. While the actual numbers of reported pregnant single women is very low (n=11), and caution is needed drawing any conclusions from this data, there appears to be a tendency for the

surveyed women not to seek services during pregnancy, with only four out of the 11 reporting a check up. Given the cultural mores around premarital sex it is understandable that pregnant unmarried women may not seek formal medical services.

The National Reproductive Health Strategy of the MoH recommends at least three pre-natal care visits during pregnancy<sup>16</sup>. On average, pregnant women reported 3.3 checkups, with 4.3 in urban and 3.1 in rural areas, and 2.7 for young women from ethnic minority backgrounds.

The table below indicates the uptake rate of both preventive services and specific pregnancy interventions for different sub-groups of young women. Consistently ethnic minority young women access services and specific interventions, including iron supplementation and tetanus injections, less than other rural young women and far less than urban women.

Just over 80% of women received prescribed tetanus shots during their most recent pregnancy, with similar urban and rural figures, although the ethnic minority group reported a lower figure of 63.7%.

A large majority of women had a health professional in attendance at their most recent birth. However, this was more likely in urban areas (94%) compared to rural areas (80.7%). Less than half the young women from ethnic minority areas (47.4%) reported having a health professional in attendance, with 36.3% having a family member in attendance and 8.1% having a traditional birth attendant. In contrast to Kinh, most ethnic minorities are not accustomed to delivering in health facilities and previous research suggests that in some ethnic minority areas 90% of deliveries are unattended or assisted by a family member. Family members were highly unlikely to be in attendance at Kinh women's births (0.4%). Ethnic minorities are less likely than Kinh to use public health facilities except for severe conditions. The reasons for this have been suggested to be remoteness from services, poor quality local services, and a more relaxed and natural attitude to life and health<sup>17</sup>. In some ethnic

**TABLE 8** *Knowledge and Utilization of Maternal Health Interventions (% Yes)*

Knowledge and Behavior of Pregnant Women	Urban	Rural	Ethnic Minority	Total
Pregnant women heard of anemia	88.0	79.3	69.8	80.7
Women had prescribed tetanus shots during last pregnancy	85.3	81.7	63.7	82.3
Women who took iron pills during most recent pregnancy?	61.5	58.2	38.1	58.7
Percentage and number of pregnancy check ups	90 4.1 visits	82 3.1	64.4 2.7	83.3 3.3

groups, women do not want to have medical examinations or delivery assistance from a male doctor.

#### 4.12. Experiences of Abortion

Although 85% of young women who had been pregnant said they had given birth, only 7.2% reported ever having had an abortion, and about 3.6% reported a miscarriage during their first pregnancy. There appears to be some inconsistency in the reporting of experiences about pregnancy and the outcomes of pregnancy, and this may be related to the sensitive nature of reporting abortion and/or miscarriage.

Reported abortion cases were small, with a total of 54 cases mainly occurring in married women, with only three cases reported by single young women. Six cases of abortion were reported among ethnic minority groups. A youth reproductive health survey carried out in seven provinces in 2003 found similarly low reports of abortion by unmarried young women<sup>18</sup>.

This seemingly low abortion rate is likely to be influenced by the high number of very young women in the sample recently married and keen to reproduce. It is usual for young women to have a baby soon after marriage with previous studies reporting that 85% of married women without children are trying to have a child<sup>19</sup>. However, it is important to note that abortion is stigmatized, particularly for

unmarried young women, and therefore under-reporting is to be expected. It is also possible that with improved and increased access to contraception the abortion rate in Viet Nam is further decreasing, as noted between 1998 and 2002.

The decision to have an abortion was made by young women themselves (rather than husbands or parents) about half of the time (55.6%). This percentage was higher for urban young women (73.8%) compared to rural, where less than half the young women reported having made their own decision about having an abortion (48.4%). Husbands appear to have a greater decision-making role in rural areas compared to urban husbands. Parents made the decision in a few cases for urban young women aged 22-25 years. This may reflect the involvement of parents when the young woman is unmarried.

Prior review of abortion data in Viet Nam has noted the scarce statistical evidence and inconsistency in abortion data. While records suggest abortion rates may have doubled from mid 80's to mid 90's (7-800,000 to 1.5 million) the MoH report that figures decreased between 1998-2002 and appear to have stabilized<sup>20</sup>.

The Demographic and Health Survey 2002 omitted never married women from abortion questions<sup>21</sup>. However total abortion rate TAR (defined as the number of abortions during a woman's reproductive years) is 0.5 for married women aged 15-49. TAR in 2002 for married 15-19 years and the 20-24 years was .001 and .016 respectively. Previous research has

suggested that when calculating the abortion rate 10% of pregnancy terminations occur among never married (or unmarried) women<sup>22</sup>. In 1998 Youth Union data suggested that one third of menstrual regulation or MR's procedures were performed for young unmarried women. Other reports suggest that abortions by unmarried young women make up between 10-20% of all abortions in urban areas.<sup>23</sup> Compared to other surveys, SAVY seems to have under-reported actual abortion figures.

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## Chapter 5

# Awareness, Knowledge and Seeking Information about Reproductive Health

Respondents were asked about their awareness of a range of sexual and reproductive health issues. The four key areas explored were family planning, pregnancy and menstruation, gender and sexual relationships, and love and marriage. The average number of topics that young people reported they had heard about was 3.4. 95.5% of the sample had heard of at least one of the four topics. The number of topics young people had heard of increased with age, from 3.2 for the 14-17 year olds, 3.5 for those aged 18-21, and 3.6 for the oldest group of 22-25 year olds.

### 5.1. Awareness of Reproductive Health Topics

Generally speaking, a high percentage of youth had heard about each listed topic, with the lowest awareness levels for pregnancy and menstruation (77.7%), and the highest awareness for family planning (92.4%). There was no notable difference between young men and young women, but there is a clear difference when comparing Kinh young people with those from ethnic minority areas. The latter group, as clearly shown in Graph 22, was less

aware about every topic relating to reproductive health, with differences ranging from 14-17%.

Young people in rural areas were slightly less aware of sexual and reproductive health topics, with the exception of their awareness of family planning. This may be explained by the extensive nationwide family planning campaigns that have taken place over the last two decades, compared to fewer programs or campaigns on other related issues like gender. Therefore, it is important to address other reproductive issues, such as gender/sexual relationships and pregnancy, in planning future programs.

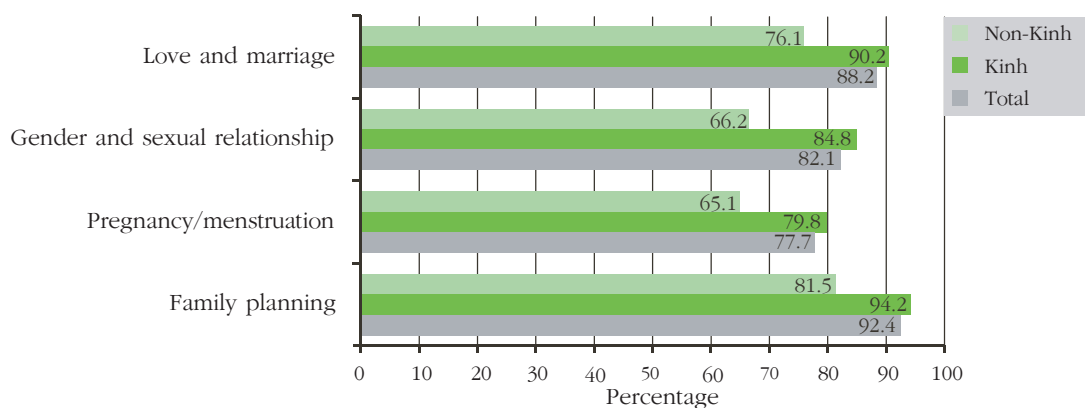
SAVY results show that awareness of an issue does not necessarily correspond with knowledge and understanding in that area. This is clearly demonstrated in results that show relatively high rates of awareness of family planning, pregnancy and menstruation, yet much lower rates on a knowledge question about the fertile period of a menstrual cycle: less than 30% of young respondents could answer this question correctly.

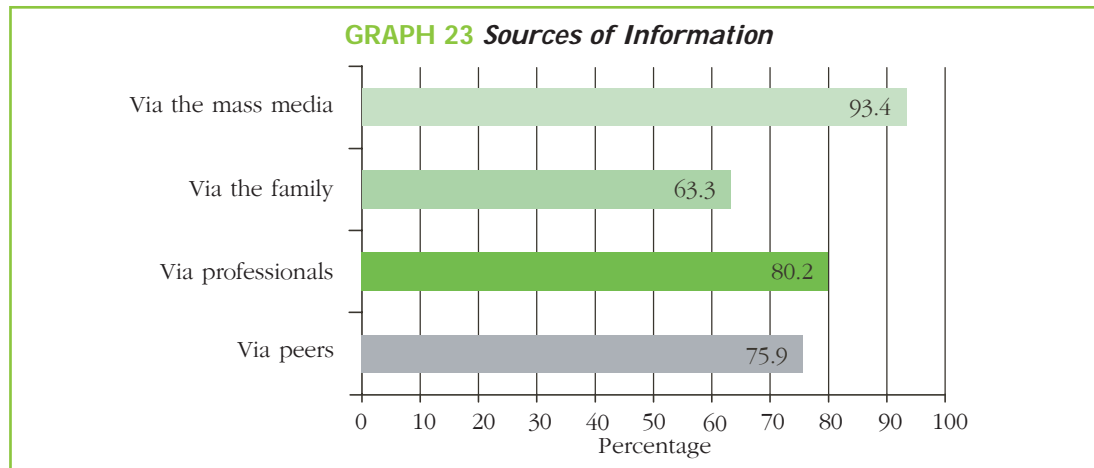
### 5.2. Sources of Information

Young people were asked to identify from where they had accessed their reproductive health information. They were provided with an extensive list of 15 different sources of information. These responses were then categorized under four main sources of information:

- Mass media: television, radio, newspaper and magazine, books and the Internet.

**GRAPH 22 Awareness of Reproductive Health Topics**





- Family: mother, father, sister, brother.
- Professional: teachers, health professionals, Population and Family Planning volunteers.
- Friends: peers, boyfriend, girlfriend.

On average, young people had 3.1 scores for information sources out of a possible score of 4. This ranged from the lowest score in the male ethnic minority group (2.6) to the highest in the 22-25 year old urban female group (3.5).

As seen in Graph 23, mass media was reported to be the most common medium for informing youth about reproductive health (among the four listed topics). Interestingly, there is a difference of only 5% between the abilities of urban and rural youth to access this information via mass media (97% for urban as compared to 92% for rural areas), despite the fact that only 73% of rural youth reported having access to television.

Accessing information via professionals was rated as the second most common medium (80.2%), including teachers (67.8%), health professionals (47.6%), and Population and Family Planning volunteers (42.3%). There was a marked difference in the percentages of married and unmarried young people accessing information from family planning volunteers, with married people accessing information at 62% compared with unmarried at 36.3%. Younger respondents, or those in school, were more likely to receive their information from teachers than from other sources (between 70-80%). This does indicate that teachers in middle secondary/high school are communicating some reproductive health information. It is difficult to assess from this survey how comprehensive the school reproductive health

programs are. While mass media can reach young people with messages, teachers may be better placed to assist youth in developing life skills, which cannot be communicated as easily through mass channels. In addition, Behavioral Change Communication should also be strengthened among health workers.

Very clear gender differences were reported in accessing the family as a source of information, with young women (84.9%) far more likely than young men (62.7%) to seek and access reproductive health information from their families.

### 5.3. Sharing Experiences of Puberty

In the survey, young people were asked whether they had ever talked to someone about their own experiences of puberty and, if so, with whom. Results show that there was a substantial gender difference in these responses: although approximately half of all respondents talked to someone about their experience of puberty, girls (80.6%) far outnumbered boys (14.9%) in sharing their experiences. Similarly, far more girls (91.1%) than boys (24.2%) discussed puberty with someone in their family. One explanation could be that first menarche usually causes more anxiety among young girls, and that they need more hygiene instruction and support at this time from adults than boys do regarding their puberty issues.

Of the young women who shared their experiences, 92.6% tended to talk to family and relatives, mostly to their parents. Young men, on the other hand, preferred to talk to their friends (72%), though the younger the boy, the more likely it was that he

**GRAPH 24 Talking to Others About Puberty**

would talk to a family member (42% of boys aged 14-17 in urban areas, versus 31.1% in the 18-21 group and 13.3% in the 22-25 group; similar percentages were found among rural boys, with 42%, 14.2% and 13.4% of boys discussing puberty with their family members).

It is encouraging that the youngest girls or adolescents tended to report talking more about their experiences of puberty when compared with older girls (across age brackets, 92%, 89% and 85% in urban areas; 86%, 74% and 69% in rural areas), suggesting an increased awareness and openness to discuss previously hushed or hidden issues.

Overall, 75.9% of young people reported hearing about the four topics from their peers, with the oldest group most frequently relying on their peers for information (85.1%) compared with the younger groups (82.2% of 18-21 year olds and 66.6% of 14-17 year olds). This could be expected, as these matters tend to be discussed among older peers and are considered to be less acceptable discussion among younger age groups.

#### 5.4. Mass Media as an Information Source

Mass media has been highlighted as not only a means of entertainment but also a good source of information, and the latter was the focus of this survey. As previously mentioned, mass media was the most common source of reproductive health information for all groups of young people in the survey. From the list of mass media sources

(television, radio, books, newspapers/magazines and the Internet) young people were given a score out of four, with five being having access to all the mass media sources listed. The average score was 3.1.

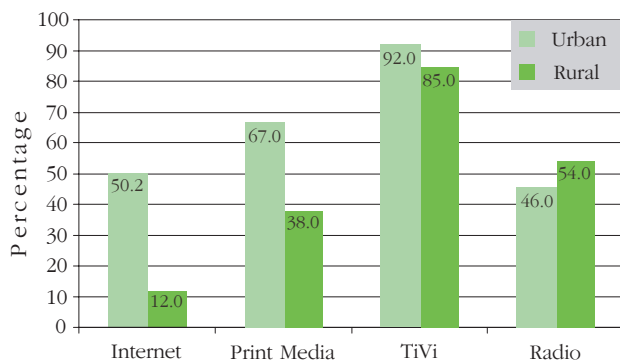
Youth were also asked how often they watch TV, listen to the radio, or read a newspaper or magazine. Results show that television is still the major source of information.

- Television: 86.5% of respondents watch TV at least twice a week; 50% watch daily.
- Radio: 52% listen to the radio twice a week.
- Print Media: 45% read newspapers or magazines twice a week.
- Internet: used by 17.3%; showing big differences between urban (50.2%) and rural (12.8%).

The respondents' access to information is noticeably different when comparing rural and urban areas. There is an increased use of television, reading material and the Internet in urban areas, but a greater use of the radio in rural areas (see Graph 25). This is easily explained by economic status, as the Internet is the most costly, newspapers and magazines also must be purchased, and television is not available in all homes in rural areas. This gives a good indicator of what sources should be targeted when developing future information programs.

Although only 73% of youth in rural areas have television in their households, 85% of them watch TV regularly, either at friends, neighbors or cafes, making television watching sometimes more of a social event. Favorite TV programs are movies, including soap opera (29.4%), news (23.9%) and music programs (23.2%). Favorite radio programs are

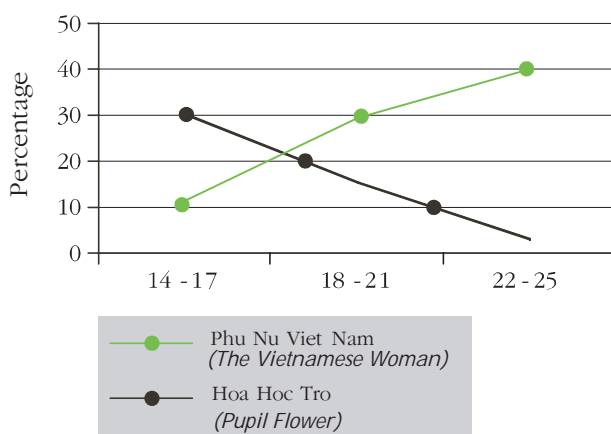
**GRAPH 25 Use of Mass Media**



music (40%), story telling (22.2%) and news (10.5%). Favorite newspaper/magazines are sports magazines or papers (11.9%), Vietnamese women's magazines and newspapers, including the weekly *Phu Nu Viet Nam* (The Vietnamese Woman) (11.3%), and *Hoa Hoc Tro* (Pupil Flower), a weekly magazine for young people, but more popular with girls (10.3%).

As youth become older they tend to shift to more serious programs. The trend is for boys to prefer *The People's Police* newspaper and news on TV, while girls list reading the very popular weekly magazine *Hoa Hoc Tro* (Pupil Flower) and start to prefer, as they grow older, the more mature subject matter of *Phu Nu Viet Nam* (The Vietnamese Woman).

**GRAPH 26 Female Reading Preferences by Age Group**

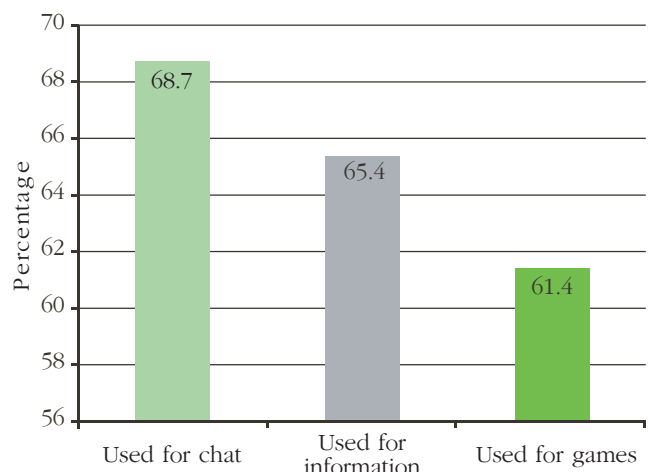


## The internet

Young people are clearly aware of the Internet as a source of information and entertainment: 90.3% of

urban and 65.6% of rural respondents have heard of the Internet. However, its use is still low. Overall, only 17.3% of respondents have used the Internet, with young people in rural areas using it four times less than their urban counterparts (50.2% in urban areas versus 12.8% in rural areas). At the present time, the small numbers that use the Internet are more likely to use it as an entertainment source rather than an information source. The majority of respondents said that they used the Internet for chatting (68.7%), and 61.4% use computers or the Internet for games.

**GRAPH 27 Most Common Use of the Internet**



## 5.5. Awareness and Knowledge of Reproductive Health

### Sexually Transmitted Infections (STIs)

Young people were asked if they had heard about a range of nine different STIs in addition to HIV. On average respondents had only heard of 3 STIs. Awareness ranged from 4.7 for the 22-25 years-old urban males, down to 2.5 for the 14-17 years-old rural males, and 2.1 for the ethnic minority group. Awareness of STIs appears to be lower than awareness in other reproductive health related topics, including HIV. Awareness rates between married and unmarried groups were similar.

The chart below shows that respondents had the greatest awareness about Hepatitis B (72.2%).

Awareness about Hepatitis B was consistently high across different groups, although notably higher in

the urban older male and female group at 81%. The relatively high number of respondents had heard of syphilis and gonorrhea, at 61.9% and 62.8% respectively. Trichomonas was recognized by 24.5%, with more rural than urban recognition. Similar percentages had heard of herpes and genital warts at 20.4% and 21.8% respectively. Only 7.2% of respondents had heard of chlamydia. There was a strong association between chlamydia and age, with older respondents much more aware of it.

Graph 29 shows the difference within and between different groups regarding their awareness of gonorrhea and syphilis. Again the older urban respondents were most aware of syphilis (87%) and gonorrhea (91%). There was a marked difference of awareness rates between rural and urban young people for syphilis and gonorrhea, with urban groups

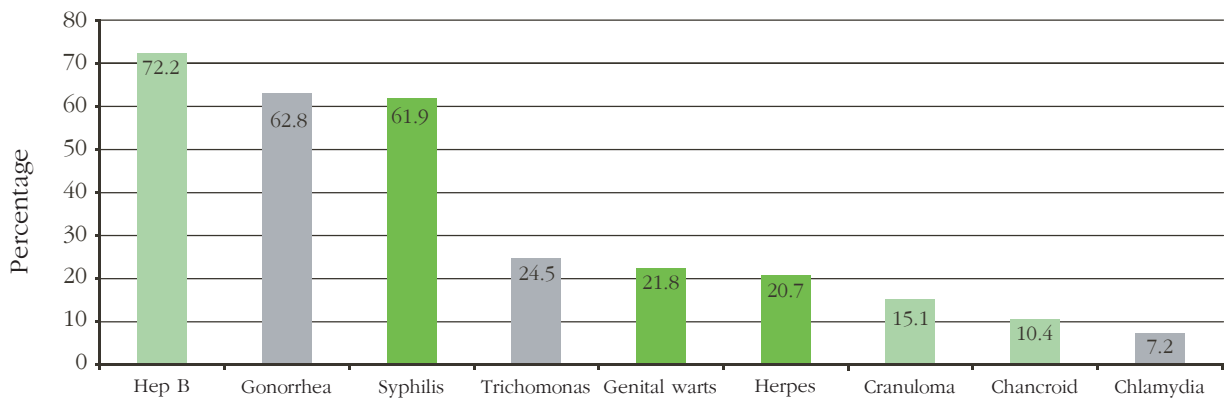
aware by around 20% more on each indicator.

A very small number of young people reported having had an STI (0.3%). However this was 0.5% for the married group and 0.2% for the sexually active unmarried group. While this number is very small, of those that did report an STI, most went to a public health facility, and a few to a private clinic. A few treated themselves, with another two young people reporting to do nothing.

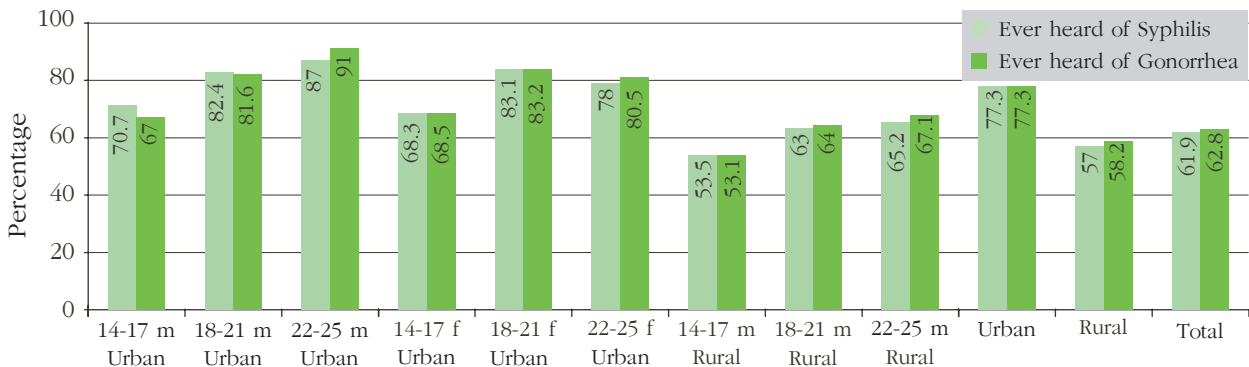
### Knowledge about Menstruation

Of some concern is the lack of correct information about the fecund times in the menstrual cycle, with only 27.8% having correct knowledge. Females had better knowledge (33.3%) compared to males (21.1%). Perhaps surprisingly, knowledge levels were

**GRAPH 28 Awareness of Sexually Transmitted Infections**



**GRAPH 29 Knowledge of STIs Across Age**





identical for the married and unmarried groups (27%).

This finding is a concern in terms of young people being able to exercise control over their fertility, and their ability to make informed choices about sexual activity with an understanding of all the possible consequences. While young people may be aware of contraception methods, not knowing when is the most crucial time to use such methods may reduce the method's effectiveness. Young women should also learn about irregularities in cycles, and that precautions need to be taken anytime that sexual activity occurs. Clearly education and information/campaigns (IEC) messages about fecund times for women have not been well communicated and it is possible that other aspects of reproductive health are poorly understood or confused. This demonstrates a need for this type of information and knowledge to be dealt with in more detail, and for an increase in one-on-one or more intensive discussion and education rather than a reliance on mass messages. Understanding such vital elements of reproductive health, is currently demonstrated by the SAVY data as being inadequate.

### Contraceptive Knowledge and Practices

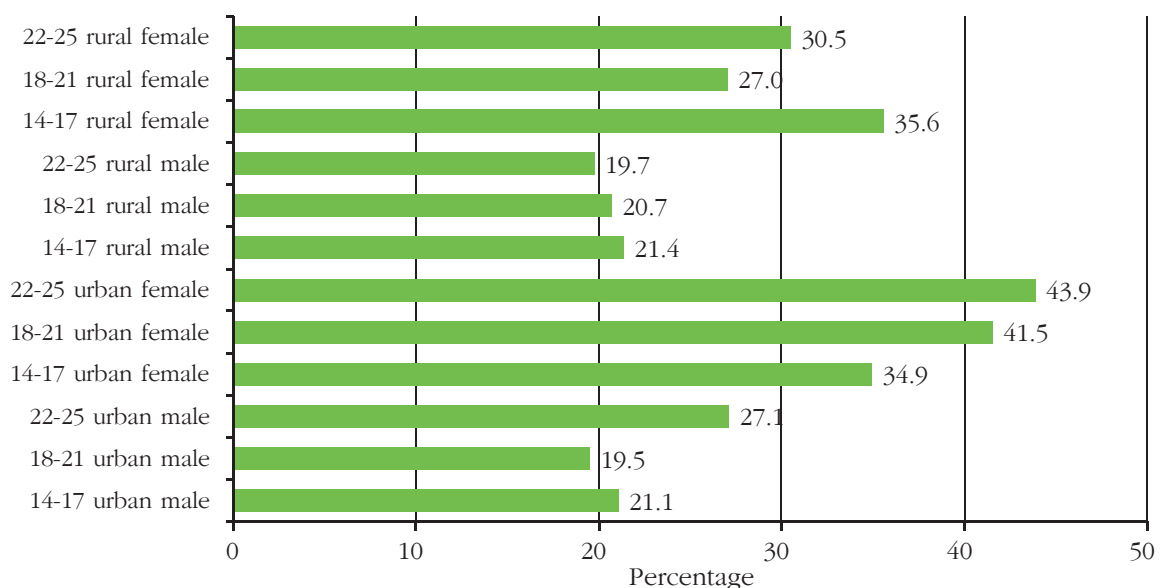
Young people were presented with a range of contraception methods and asked which ones they

had heard of and which ones, if any, they had used. The vast majority of young people knew of at least one contraceptive method (97%), and on average the number of contraceptive methods known was 5.6 out of a possible 10. There is a clear age relationship with the oldest age groups knowing more contraceptive methods than their youngest counterparts, both in urban (7.3% for males, and 7% for females) and in rural areas (6.4% for males and 6.9% for females).

Only 14% of the total sample reported having used contraception. There was a huge difference between the married and unmarried groups, with 71.6% of the married group having used contraception compared with only 3.8% of the unmarried group. The rate of contraception use at the time of interview was reported to be 59.4% by the married group and 2.1% by the unmarried group. This must be considered in the context of the fact that the overall sexually active rate in the unmarried group is only 4.9%.

All sexually active young people were asked whether they had used contraception for their first sexual experience. Of the married sample, 88% had used contraception at the time of first sex compared to just over half of the single sexually active group, at 51%. The married groups most commonly reported that the contraceptive method used at first sex was condoms (41.9%) followed by the contraceptive pill

**GRAPH 30 Knowledge about the Menstrual Cycle**



(30.4%). The single group had a much higher reported rates of condom use (79.9%) than use of the contraceptive pill (only 6.1%). Reasons for these differences may include barriers to accessing the contraceptive pill for single women, safe sex messages or HIV messages influencing single young people to chose condoms for dual protection, and initial sexual experiences of some young singles occurring with sex workers and hence an increased acceptance or preparedness to use a condom.

Another measure of contraceptive use was gauged by asking the question: “At your last sexual experience did you use contraception?” 52.5% of the married sample had used contraception during last sex compared to a reported 66.8% of the unmarried sexually active sample. Similarly high rates of contraceptive use were reported by sexually active young people at their first sexual intercourse.

Young people were asked the reasons for not using condoms during first sex. The answers differed depending on if the person was married or not. Many married people reported that they did not want to use a condom, while the most common

reason that unmarried people did not use a condom at first sex was because they were not planning to have sex. A small number of respondents reported that they did not know how to use condoms and also because their partner did not want to. This question also had an extremely high ‘other’ response (30%) suggesting too few options were provided for this question, or perhaps due to some other cultural reasons, for example the stigma associated with condom use, which was not offered as an optional answer.

### Condoms as a Method of Contraception

Of all respondents, 70% said that condoms reduced sexual desire. As already mentioned, the majority had not used condoms. It could be interesting to further explore from where do young people get their information/perceptions about condoms, why they feel it decreases pleasure, and whether messages to promote condom use can become more acceptable or less stigmatized.

98.5% of young people recognized that condoms could reduce pregnancies, HIV and STIs. Pricing was not identified as a major barrier to condom use, with only 25% reporting that condoms were expensive.

This survey provides good insight into understanding the way youth seek information about reproductive health, as well as their awareness and preference for information source programs. This information is essential for designing future programs in order to improve young people’s knowledge and skills relating to reproductive health. Looking carefully at disaggregated data about age, gender and location gives us rich information for targeting certain groups.



## Chapter 6

# HIV/AIDS

The SAVY questionnaire explored a range of HIV related aspects including young people's awareness and knowledge levels, prevention strategies, sources of information, preferred methods for receiving HIV information and messages, and attitudes and behaviors toward people living with HIV/AIDS (PLWH).

One of the aims of the National Strategy on HIV/AIDS Prevention and Control in Viet Nam until 2010 is to raise people's knowledge about prevention of HIV transmission so that 100% of people living in urban areas and 80% of people living in rural and mountainous areas shall be able to correctly understand and identify ways of preventing HIV/AIDS transmission.<sup>1</sup> SAVY results suggest that this aim may well be realized for Vietnamese young people if future efforts focus on correct understandings and targeted interventions for young people from ethnic minority areas.

### 6.1 Awareness of HIV/AIDS

A most encouraging finding from SAVY is that, nationally, 97% of respondents reported that they had heard of HIV/AIDS, with this percentage increasing to 100% for urban respondents. Awareness is also relatively high among ethnic minority young people (84.7%), and those from the North West region (82.1%). Of note is that nearly one-quarter of young people (24.3%) never attending school had not heard of HIV/AIDS. These figures raise several points. Firstly the very high awareness levels support the fact that HIV/AIDS IEC campaigns in Viet Nam have been very successful in reaching the vast majority of young people and raising awareness about HIV/AIDS across regions, in both urban and rural areas. Although not a national survey, a large study was implemented in 1999 in Hai Phong with 15-24 year olds. This found that 70% were aware of HIV, when asked the question: "Have you heard about HIV?"<sup>2</sup> The SAVY figure of 97% seems to indicate that awareness of HIV has increased over the past five years.

While HIV awareness is high nationally, IEC activity

as indicated by the figures above has been less effective in reaching ethnic minority young people and those who have never attended school. Reasons for the lower awareness levels of some groups, in the face of such nationally high figures, may include lower IEC implementation in remote areas, low education levels which mitigate against an understanding of HIV messages, a lack of appropriate targeting of messages for different groups, and language barriers posed by media campaigns that are conducted only in the Kinh language.

### 6.2 Sources of HIV Information

The survey determined the most common delivery points from which young people received their information about HIV/AIDS. Respondents identified all information sources from a possible list of nine different information sources including: television/radio/magazines; loudspeakers; posters; meetings; leaflets and books; health professionals; teachers and schools; friends; mass organizations; and family. A score out of nine was calculated, with each information source being equal to one point. A score of 7-9 points was categorized as having 'many sources of HIV information' and 0-6 as having 'fewer HIV information sources'.

Just under half of the total sample reported having many sources of HIV information (49.3%), with slightly higher percentages of males (51.5%) compared with females (47%). Urban young people appear to be at an advantage in having many sources to access HIV information (57.5%) compared with their rural counterparts (46.7%). The most disadvantaged groups in terms of HIV information sources are the youngest rural females and ethnic minority young people, with only about one third of both groups having many sources of HIV



information; in other words, two thirds had few sources of HIV information.

Significant differences were reported by age groups, with the eldest respondents far more likely to have many HIV information sources (58.1% for those aged 22-25) compared to the youngest respondents (41.7% in the 14-17 year old group).

The nine listed information sources were also grouped into four categories: mass media, professional services including schools, family and mass organizations. Overall, 61.6% of respondents had access to all four-category sources of HIV information, with a trend for older and urban respondents to report slightly higher scores.

Graph 31 clearly shows that mass media is the most common source of information on HIV for young people, at 96.5%. This is the case across all age groups with similar results for males and females, and for urban and rural areas. While the majority of ethnic minority young people also report accessing mass media for HIV information at 83.2%. This is again noticeably lower than their Kinh counterparts, at 98.7%.

The family was the second most commonly reported source of information (88.2%), with urban young people more likely to have family as a source of HIV information than their rural counterparts (92.6% compared to 86.7%). An interesting but somewhat contradictory finding is that similar numbers of young men and women reported talking to their family about HIV, but far fewer young men (48%) than young women (78%) reported talking to their family about reproductive health. One possible reason for the apparent ease or increased openness with which young men can discuss HIV in the family, compared to discussing reproductive health,

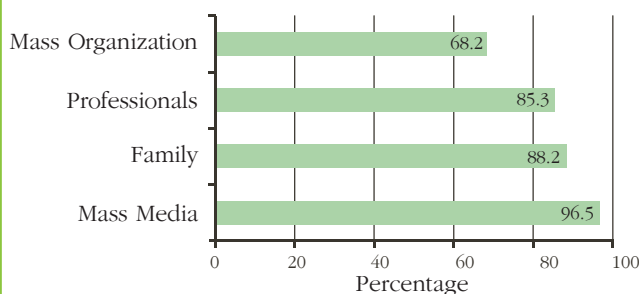
may be the portrayal of HIV as a predominantly male issue (linked to drug use and sex workers) rather than HIV being linked to relationships or reproductive health. Families may warn their sons to stay away from drugs and social evils without necessarily having further discussion about related sensitive issues, notably sexuality and reproductive health. Further research is needed to better understand how conversations about HIV are conducted within the family environment for both young men and young women.

Professional services (health workers and teachers) are another very important source of HIV information, reaching 85.3% of young people. Higher percentages of urban young people (92.5%) had accessed HIV information from professional services compared to their rural counterparts (82.9%).

Graph 31 shows that just over 68% of young people (broken down to 60% of ethnic minority groups) have received HIV information from mass organizations. Although the least likely of the four HIV sources of information to be identified, mass organizations are clearly an important provider, reaching just under seven in 10 young people. The data does not allow for identification of exactly which mass organizations are the source, but it can be noted that both the Youth Union and the Women's Union report that they have a focus on young people and HIV.

Very few respondents reported no HIV information sources (3%). However this figure is far higher in ethnic minority respondents (15.5%). Particularly concerning is the 19.4%, or nearly one in five, ethnic minority young women reporting to have no source for HIV information. Such a figure suggests the need for more targeted HIV intervention for particular groups and regions. Without access to information, young women are unable to take action to protect themselves, or to participate in community prevention and care efforts. The most recent HIV figures suggest that HIV already affects one in every 75 houses nationally in Viet Nam<sup>3</sup>.

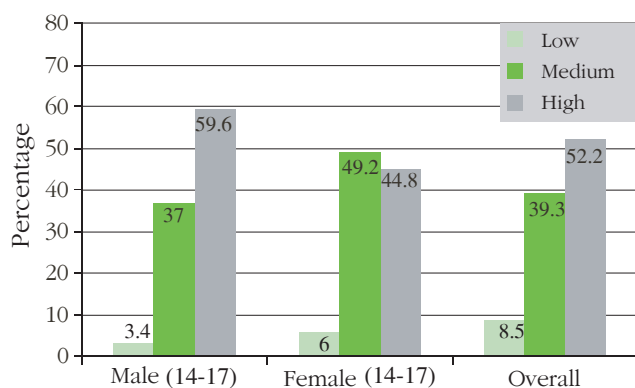
**GRAPH 31 Access to Information Sources about HIV**



### 6.3. Knowledge Levels about HIV

To gauge young people's knowledge about HIV/AIDS, the survey asked respondents 15 different questions about the physical appearance,



**GRAPH 32 Knowledge Levels about HIV/AIDS of Urban Males and Females**

actions and behavior of people living with HIV, as well as the actions and behavior that could prevent the transmission of HIV. A score out of a possible 15 was then created. Respondents with scores between 13 and 15 were regarded as having high levels of knowledge, 9-12 as medium, and eight or fewer as having a low knowledge level. The mean score on HIV knowledge for the sample as a whole was 12.6. The highest means were recorded for the 22-25 year old urban males (13.4) and females (13.3). There is a significant difference between average knowledge scores for Kinh (13.0) and ethnic minority young people (10.2). Graph 32 indicates that just over half, or 52.2%, of SAVY respondents had high levels of knowledge about HIV, 39.3% had medium knowledge, and 8.5% had low knowledge levels.

More of the older respondents (22-25 age group) had high knowledge levels and more males than females had higher levels of knowledge. Graph 32 also shows a rather large difference between the high knowledge levels of urban adolescent males aged 14-17 years (59.6%) compared with a lower percentage in urban adolescent girls higher knowledge (44.8%). Slightly more urban young people had higher scores than rural counterparts (54.4% for urban compared to 51.6% for rural), and less urban young people had low scores than rural (3.9% compared to 9.9%).

Of some concern, however, are the low levels of knowledge recorded from ethnic minority young people. While only 5.5% Kinh have low knowledge levels, 26.5% of ethnic minority young people have low knowledge, with 30.5% for ethnic minority young women. Similarly, this discrepancy exists in those

with high knowledge. More Kinh young people recorded high levels of knowledge (54.7%) compared with their ethnic minority counterparts (37.5%).

In assessing knowledge about HIV/AIDS, young people were asked: "Is it possible for a person who looks healthy to have HIV?" The majority (84.5%) provided a correct "yes" response to the question. This fact was better known amongst urban young people (89.4%) compared to rural young people (82.8%). The VNDHS 2002 asked young married women aged 15-24 exactly the same question, with only 75% of the sample answering correctly. This increase of almost 10% is a positive indicator of the reach of IEC and HIV prevention activities. SAVY comparisons to the VNDHS 2002 also show that knowledge about HIV/AIDS has increased significantly. The proportion of young people who mentioned condom use as a prevention strategy has increased dramatically from about 45% in 2002 (in married women 15-24) to 97.5% of the total SAVY sample<sup>4</sup>. While exact comparisons cannot be made between SAVY and the earlier samples, the SAVY figure (50% higher) does provide reason for optimism. It is not unreasonable to expect that young people are more knowledgeable than three years ago, given the government and development partner investment and support for greater access to HIV education, mass media campaigns and an improved policy context<sup>5</sup>.

While nationally a rather positive picture emerges about HIV awareness, and to a lesser extent knowledge, it is of some concern that as many as one in five rural 14-17 year olds girls, and 35.7% of ethnic minority young people, believe that people with HIV always look physically unhealthy or sick. This suggests that while IEC messages have raised awareness about HIV/AIDS, they may have also, unintentionally communicated incorrect or ambiguous messages to some segments of youth. Over the past few years a number of mass media HIV images have portrayed people with HIV as looking skeletal, unhealthy, unclean and perhaps socially undesirable. It is understandable that these images may have left a strong impression on some young people. Recently the government has stimulated the renovation of communication messages to minimize these misunderstandings.

Approximately two-thirds of young people (63.7%) could identify at least three different HIV testing sites. This suggests that access to HIV testing,



particularly knowing where to get a HIV test, is not a large barrier to testing for young people. However, many other factors, identified in previous reports, operate to prevent testing, including fear, lack of confidentiality, stigma around HIV, cost, lack of treatment for people with HIV, and poor processes about the sharing of results<sup>6</sup>.

#### 6.4. Means of HIV Prevention

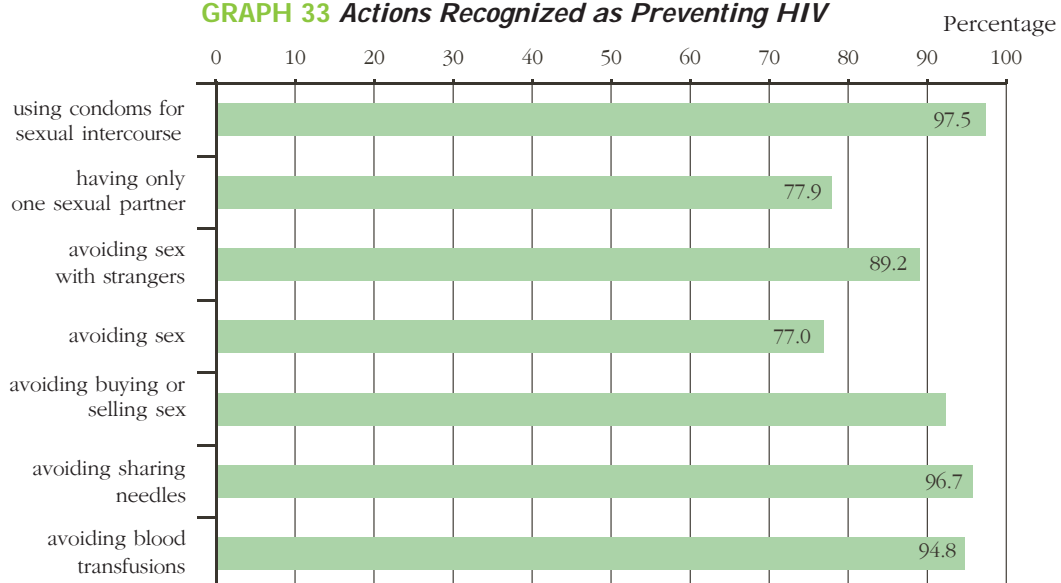
Young people were asked seven specific questions about different means of HIV prevention and generally their knowledge levels were high. 82.9% of young people knew six out of 7 strategies for preventing HIV/AIDS. Graph 33 shows that 97.5% of respondents knew that condom use could prevent the spread of HIV, followed by 96.7% of respondents who reported avoiding sharing needles as a HIV prevention strategy. 94.8% reported avoiding blood transfusion as a prevention mode, followed by 92.5% reporting avoiding buying or selling sex, and 89.2% reporting that avoiding sex with a stranger could prevent HIV.

During analysis concern was raised about the possible ambiguity of two actions listed to prevent HIV. The question posed was: “Which of the following actions are useful in preventing HIV?” followed by a list of actions. The two actions of concern were: 1. Having one sexual partner; and 2. Avoid having sex. Discussion occurred because these two questions returned the lowest correct responses

and it was felt that respondents may have been confused about whether the question was exploring the effectiveness or feasibility of the suggested actions. For example, it is possible that young people reasoned that, while abstaining from sex can prevent HIV transmission, it is unlikely to be embraced by all people. Furthermore, youth responding to the question may have understood that monogamy only works to prevent HIV if the other partner is also monogamous. Therefore, it is difficult to garner significant insight about level of knowledge from the answers to these questions. Further analysis indicated that removing the two questions did not significantly alter the level of knowledge scores. However caution should be used in considering the knowledge about abstaining from sex and having only one partner in the context of actions to prevent HIV.

According to the National HIV/AIDS prevalence and projections data young people aged 20-29 are over-represented in HIV infection rates<sup>7</sup>. However, there is no significant difference between age groups (14-17, 18-21, and 22-25, ranging from 81% to 84%) with respect to recognizing the seven methods for preventing HIV/AIDS. As has been recognized in other research studies, knowledge alone is not enough to protect young people from HIV and it is necessary also to focus on risky behaviors, notably unsafe sex and intravenous drug use, as well as the skills that people might need to protect themselves. There is some evidence that young people tend to see themselves as invincible. Qualitative interviews with young Vietnamese migrant workers from the

**GRAPH 33 Actions Recognized as Preventing HIV**



Mekong delta found that young men, even those engaging in sexually risky behaviors did not see themselves as vulnerable<sup>8</sup>.

## 6.5. Views of Condoms

Overall, attitudes to condom use were negative; for example, 70% of all respondents reported that condoms reduced pleasure and half of those surveyed felt that people who carry condoms might have improper relations. At the same time, respondents were convinced about the practical effectiveness of condoms, particularly with respect to HIV: 97% of respondents agreed that condoms could prevent HIV and STIs if used properly. Though the level of knowledge is high, the negative attitudes towards condoms reported are likely to prevent young people from using condoms. It should be noted that previous studies/surveys have recorded much lower levels of condom usage<sup>9</sup>.

## 6.6. Views of Community Treatment of HIV/AIDS

Aspects of community treatment of people relating to HIV were explored by asking respondents if they would help a man/woman in their community who has HIV/AIDS. Generally, young people reported tolerant and caring attitudes, and limited fear, of those living with HIV. 13.4% reported that they would not help someone with HIV in their community; however, the clear majority said that they would help and keep normal contact with PLWH, but would be aware of protecting themselves (83.7%). Generally, the attitudes of young men and young women were the same, as were attitudes regarding helping either men or women in their community. A very small number said they would help without qualification (0.5%), and another 2% said they would help but would keep a distance. This shows either fear, lack of information and/or discrimination by a small group against PLWH.

The data shows a marked difference in the views of particular sub-groups of young people towards treatment of PLWH. Kinh young people seem more tolerant or willing to support PLWH than their ethnic minority counterparts. Approximately three times as many ethnic minority youth (33.5%) as Kinh youth

(10.1%) said that they would not help PLWH.

Interestingly, the ethnic minority group reported the lowest levels of information, and it is probable that fear and discrimination may be linked to this lack of information.

The picture drawn regarding young people's access to HIV information from a range of sources is rather positive. It is a sign that government and development partners' efforts to reach youth have been, on the whole, successful. It reinforces the need for a range of sectors to take responsibility to deliver information and education about these very important areas. The gaps in HIV/AIDS knowledge of young people also indicate areas and mediums in which future investment might be best placed, including mass media and other channels, HIV/AIDS programs for ethnic minority young people, and development of programs with very clear messages and which provide not only information, but help to develop appropriate attitudes, as well as useful and practical skills by which young people can protect themselves from HIV/AIDS.

1. The National Committee for AIDS, Drug and Prostitution Prevention and Control. National Strategy on HIV/AIDS Prevention and Control in Viet Nam up to 2010 with a vision to 2020. Hanoi; 2004.
2. National Committee for Population and Family Planning. Adolescent Reproductive Health: Survey and Assessment of Knowledge, Attitude and Practice of Adolescents in Hai Phong City about Related Reproductive Health Issues. Hanoi; 1999.
3. The National Committee for AIDS, Drug and Prostitution Prevention and Control. National Strategy on HIV/AIDS Prevention and Control in Viet Nam up to 2010 with a vision to 2020. Hanoi; 2004.
4. National Committee for Population and Family Planning (NCPFP) [Viet Nam]. 1999. Viet Nam Demographic and Health Survey 1997, Viet Nam Demographic and Health Survey 2002. Hanoi, Viet Nam: National Committee for Population and Family Planning.
5. The National Committee for AIDS, Drug and Prostitution Prevention and Control. National Strategy on HIV/AIDS Prevention and Control in Viet Nam up to 2010 with a vision to 2020. Hanoi; 2004.
6. Khuat TH, Nguyen TVA, Ogden J. Understanding HIV and AIDS-related Stigma and Discrimination in Viet Nam. ICRW Research Report; 2004. [cited 2004 Jul 11]. Available from: [http://www.icrw.org/docs/vietnamstigma\\_0204.pdf](http://www.icrw.org/docs/vietnamstigma_0204.pdf)
7. The National Committee for AIDS, Drug and Prostitution Prevention and Control. National Strategy on HIV/AIDS Prevention and Control in Viet Nam up to 2010 with a vision to 2020. Hanoi; 2004.
8. WHO. Adolescent Migrants and Reproductive Health in the Greater Mekong Region. A Preliminary Analysis; 2004. Unpublished.
9. The National Committee for AIDS, Drug and Prostitution Prevention and Control. National Strategy on HIV/AIDS Prevention and Control in Viet Nam up to 2010 with a vision to 2020. Hanoi; 2004.

## Chapter 7

# Substance-Use

This section of the survey explored a number of areas relating to substance use and abuse including consumption, influencing factors, access to substances and the social context of drug use. Young people were also asked about the substance use of their family members.

## 7.1. Heroin and Illicit Drug Use

Reported illicit drug use by respondents was extremely low (0.5%), with only 41 cases in the sample reporting to have ever used any type of illicit drug. Of the 41 cases, 35 were young men and six were young women. Of those who said they had used an illicit drug, 10 individuals reported having injected a drug and three cases reported to have shared a needle. One limitation of the study was the inability to follow up with potential respondents who were, at the time of the survey, not living in households because they were in drug rehabilitation. In a few cases, it was reported that young men were not available for interview because they were in drug rehabilitation centers

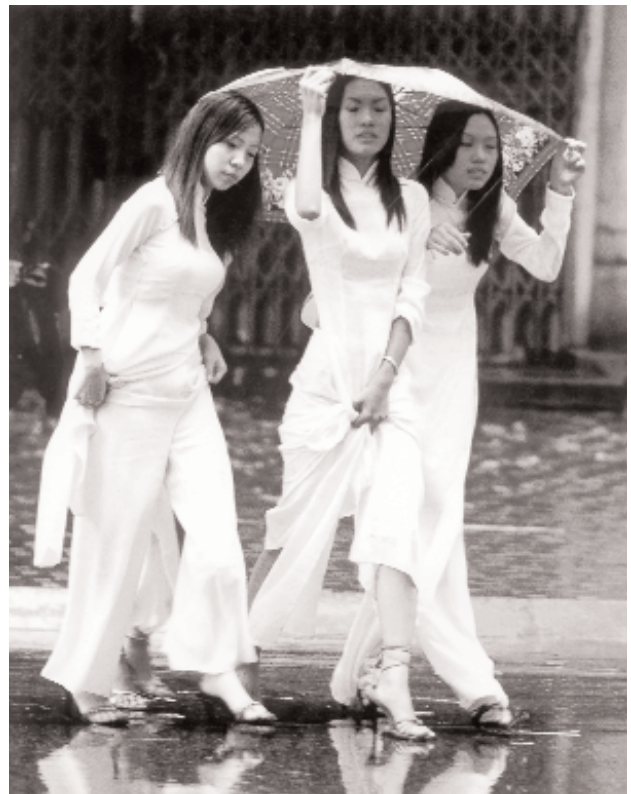
While these figures almost certainly under-report the real figures, the higher male-to-female ratio is consistent with many prior studies showing that illicit drug use is more common in young men than young women<sup>1</sup>. Under reporting of illicit drug use has been confirmed in previous surveys<sup>2</sup>. The reasons include young people's reluctance to report illegal behavior to interviewers, as they may be concerned that the questionnaire is not really confidential and that disclosure of drug use might have negative legal consequences. Fortunately, there are other sources of data from qualitative studies that provide more in-depth and realistic measures of drug use, which clearly remains a major issue for young men's physical and mental health, HIV transmission, and family conflict and stress in Vietnam<sup>3</sup>.

## 7.2. Knowledge of Illicit Drugs and Drug-users

While usage reporting was low, the majority of

respondents had heard of illicit drugs (81.8%), with urban respondents (91.8%) more likely than their rural counterparts (78.6%) to have heard about illicit drugs. Young people from ethnic minority areas were less likely to have heard about illicit drugs (64%) compared with their Kinh counterparts (84%). Across age groups and regions, the vast majority of young people knew that not sharing needles was one way to prevent the spread of HIV/AIDS (95.7%). It is reasonable to assume that extensive IEC and mass media campaigns targeting HIV and drugs prevention over the past three to five years have played some role in such high awareness levels. While very few participants reported having ever taken drugs, 26% of the sample said they knew someone who used illicit drugs. Young people from urban areas were twice as likely to know a drug user (42.4%), compared with rural groups (20.8%). While the age groups of known drug users were not directly reported in this survey, national data about drug use suggests that the majority of drug users are young<sup>4</sup>.

Young people were asked about the ease with which they could access heroin and illicit drugs within their local communities. Access to a supply of heroin was seen as difficult for the majority of the sample, with 66% reporting it was either

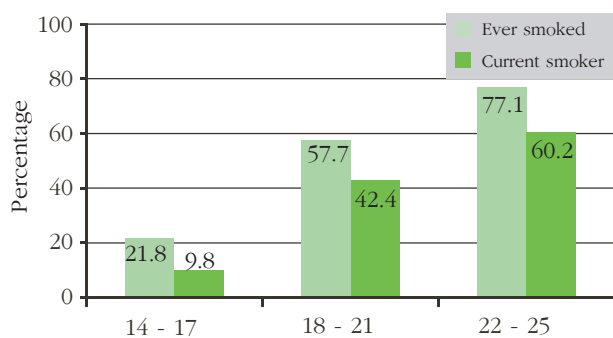


impossible or extremely difficult to obtain. In general, ethnic minority young people perceived access to drugs as more difficult than other groups. About 30% of the overall sample reported that it was 'a little difficult' to acquire illicit drugs; however, a notable 16.3% of the urban male group 22-25 years reported that illicit drugs were easy to obtain. Previous adolescent and youth studies in Viet Nam and other Asian countries indicate young urban males are a high-risk group for drug use<sup>5</sup>. Limiting access to drugs (both illicit and legal) has been suggested as a necessary and fundamental strategy for harm reduction relating to substance abuse.

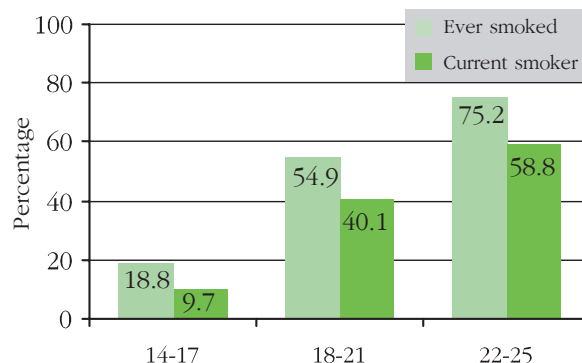
### 7.3. Smoking

The analysis of the data on tobacco use focuses on young males from the sample because there were very few young women reporting to have ever smoked (1.2%), and only one-third of these reported to be current smokers. While numbers are very small, urban females reported having smoked more than those in rural areas, with 2% of the urban 18-21 year old female subgroup reporting to have smoked. The data indicate that smoking is not yet an issue for young women in Viet Nam. However, in neighboring Asian countries with a higher exposure to advertising and the glamorizing of smoking, and where access to tobacco products has increased, young women are taking up smoking at a rapid rate<sup>6</sup>. Preventing this trend in Viet Nam, and maintaining and reinforcing the current non-smoking behavior of young women, will be a significant challenge for future public health campaigns.

**GRAPH 34 Urban Males, Ever Smoked and Current Smokers**



**GRAPH 35 Rural Males, Ever Smoked and Current Smokers**



Overall, 43.6% of young males reported having smoked at some time, with the prevalence of tobacco use increasing with age. Rates and patterns of smoking were very similar between rural and urban young men, with slightly higher rates in the urban sample. While about one in five of the youngest urban males had ever smoked (21.7%), this increased markedly in the 18-21 year olds (57.7%) and even more so in the 22-25 year old group, with more than three-quarters, or 77%, of these young men claiming to have used tobacco. The average age for the first cigarette was 16.9 years. As smoking increases with age, and at a time when young people become more socialized and involved with societal activities, interventions to prevent tobacco use should target young people at earlier ages to prevent them from developing this behavior.

71.7% of those males who had ever smoked reported to be current smokers, although this was much lower in the younger group (14-17 years), where 45% of urban and 51.3% of rural youth who had ever smoked reported to be current smokers. The total current smoker rate for this 14-17 age group is about 10%. This increased steeply with age. Of the 18-21 year age group who had ever smoked, 42.4% were current smokers. This was a little higher for the urban 22-25 age group with 60.2% reporting to be current smokers. This figure should be of major concern given the huge health costs of tobacco to individuals, the health sector and families. WHO predicts that two thirds of the adolescents living in Asia today will die from tobacco related causes in the future. Findings



suggest that intervention needs to start before age 16 (if the aim is to prevent the uptake of smoking) but efforts to intervene with those in the early stages of their smoking career are also necessary. Interestingly, and of potential interest for public health initiatives and tobacco prevention programs, is that 70% of the male smokers had tried to give up at least once, with 80% of female smokers also having tried to give up. Until very recently there has been little attention paid to cessation programs, but given the high numbers of already addicted young people this may need to be reconsidered.

#### 7.4. Reasons for Smoking

The most common reason cited for starting to smoke was “because all my friends smoked” (54%). For the 14-17 year olds, more rural males (57.2%) than urban (42.5%) reported to be influenced by friends who smoked. 13% of young men reported that they began smoking “because I was too tense”, and 11.3% started “because people around me smoked”. Only 3.4% of young men mentioned that they began smoking to show-off an adult image. Significant research indicates that advertising of tobacco products can have some effect on the reasons for smoking, as can cultural values and attitudes<sup>7</sup>.

Young people were asked how easy it was for them to obtain cigarettes. The majority (98.1%) reported that it was “easy”. Although legislation exists making it illegal to sell tobacco to anyone below the age of sixteen, in the main this law is not enforced. The environment in Viet Nam for young men is one that is rather conducive to accessing and smoking tobacco.

More than half (57.8%) of male smokers had fathers who smoked, and who may be perceived as role models, and 20% reported having brothers who smoked, while very few had mothers who smoked (3%). The environment and role models of young people clearly influence their smoking behaviors, although this does not appear to cross genders. Young women also live and socialize around smokers but do not pick up the habit of smoking. At present, the smoking culture in Viet Nam is strongly male-orientated. Culturally and historically, women’s drinking and smoking is viewed more negatively than that of men, with strong social

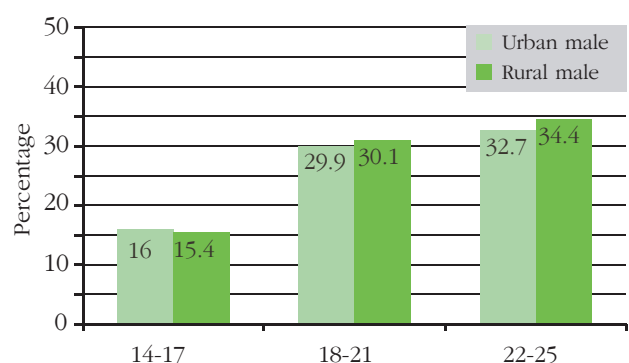
constraints and controls that mediate such behaviors. These social constraints, in fact, operate to protect young women from drinking and smoking, although there are, of course, consequences for young women that arise from men’s drinking and smoking, including being exposed to secondhand smoke.

#### 7.5. Peer Pressure and Smoking

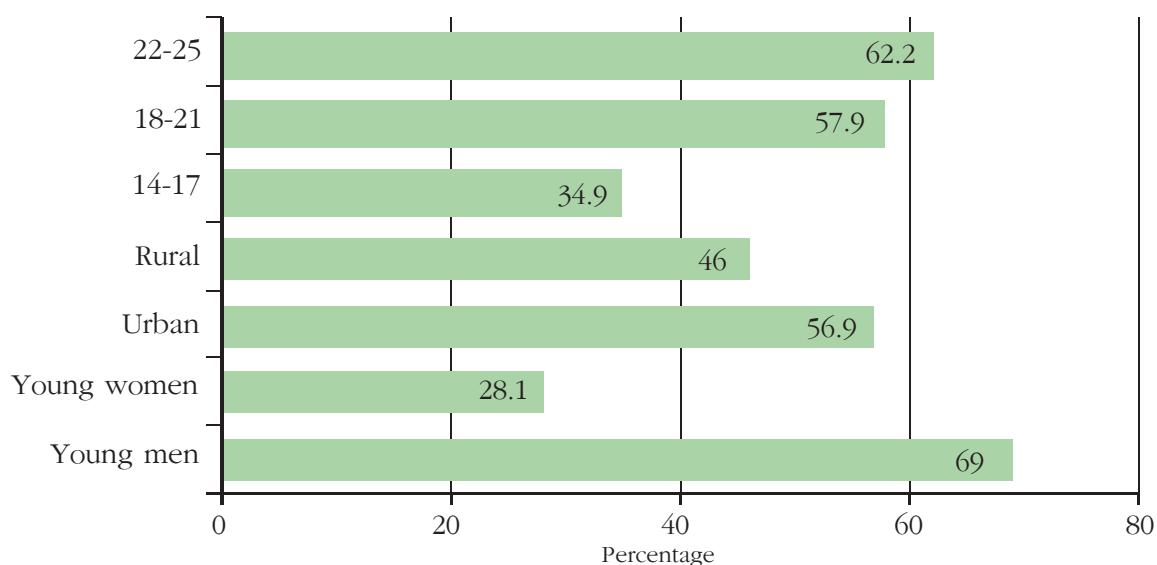
Young men reported experiencing both positive and negative pressures from their friends about smoking. Negative pressure is more commonly understood as peer pressure, or enticement by others, for young people to participate in a health compromising or problem behavior (in this case, smoking). Positive pressure is the encouragement from peers for young people to abstain from problem behaviors, such as smoking. On the whole, young men (77%) reported that their friends encouraged them not to smoke; young urban males of 14-17 years were the most likely group to report positive peer pressure to abstain from smoking (79.7%). At the same time, almost one-quarter of males (24.3%) indicated that they faced negative peer pressure to smoke. This negative pressure appeared to increase with age, with the youngest group of males to report relatively little peer pressure to smoke (16% for urban and 15.4% for rural 14-17 year olds) but the 22-25 year olds reporting more than twice those proportions (32.7% for urban and 34.4% for rural males).

Young women reported very little peer pressure to smoke (0.5%). Interestingly, however, fewer young women than men reported that they were

**GRAPH 36 Peer Pressure to Smoke**





**GRAPH 37** *Young People Who Have Ever Finished a Glass of Beer or Liquor (by Age, Location, and Gender)*

encouraged by friends not to smoke (73.5% of women, versus 77.0% of men). This may be due to the multiple choice answers to the questions, as each question on positive peer pressure was dichotomous (either friends ‘encourage’ or ‘do not encourage’). It also may be due to cultural norms that mean that smoking is not an accepted activity for women.

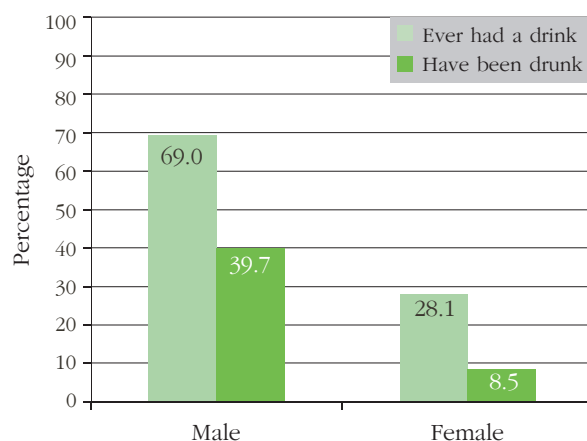
## 7.6. Alcohol

To explore and understand alcohol use, all participants were asked if they had ever finished a glass of beer or other type of alcohol. The results indicate that while drinking is a behavior of the majority of young men (69%), it is less so for young women, though still a common behavior at 28.1%. Drinking is more common among urban (56.9%) than rural (46%) young people. As predicted, the percentage of young people ever having had a drink increases with age, with reported rates of 34.9% for 14-17 year olds, increasing to 57.9% for 18-21 year olds, and further increasing to 62.2% for 22-25 year olds.

Of those who had ever finished a drink of alcohol (referred to as drinkers), 58% of the males and 30% of the females reported to have been drunk at least once. Being drunk was defined as being physically

affected by alcohol or under the influence of alcohol at least once.

In terms of the total sample, 39.7% of the males had been drunk and 8.5% of the female sample had been drunk. While these figures may be perceived as rather low – and certainly lower than countries like America, Australia, France and Britain – they do include the adolescent group of 14-17 year olds who are mainly non-drinkers. This data highlights the need for disaggregated data to clearly

**GRAPH 38** *Drinking Behaviours of Young Men and Women*

identify which groups are drinkers, and what are the frequency and consumption patterns. Prevention activities in the area of alcohol use can include reinforcing non-drinking behaviors and encouraging sensible or safer use of alcohol by those who do drink or do get drunk.

Graph 38 shows that while many young people have sampled alcohol, the percentage of those who had ever actually been drunk is relatively small, possibly suggesting that many young people are using alcohol in moderation or responsibly and that alcohol use is not problematic for most youth. There is, however, a very marked gender difference, with many more boys reporting to have been drunk than girls and a small group of young men who repeatedly get drunk.

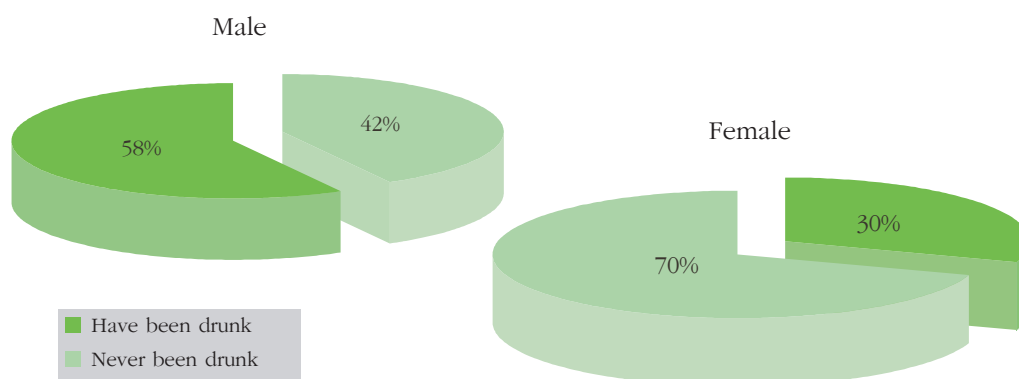
From a public health and adolescent health perspective it may be timely to look at the groups who are drinkers and consider what risks they may face, and the possible prevention messages and strategies that will protect them from becoming heavier drinkers. Graph 39 illustrates that within the groups who do drink, a significant number have been drunk, and this occurs twice as much in boys as in girls. The fact that 30% of the group of young women who drink have been drunk may suggest that social controls around female drinking are lessening and acceptance, even encouragement, of young women's and women's drinking may be emerging as a by-product of economic growth and globalization, as seen in many other countries. Adult drinking patterns are generally established during the adolescent and youth years. Increased alcohol

use – and the associated physical and social health problems arising from alcohol use – is a predictable outcome in a country with increasing expendable income and easy access to alcohol.

## 7.7. Access to Alcohol

Young people were also asked about the ease of access to alcohol within their community. In other countries easy access to alcohol by young people has been identified as a risk factor associated with alcohol and drug use, violence, and early sexual experimentation<sup>8</sup>. SAVY found that the vast majority of young people reported that it was very easy to access alcohol (98.6%), and this figure was similar for all groups. Compared to some other Asian countries, alcohol appears to be more easily obtainable by young people in Viet Nam. Alcohol is readily available and consumed in shops and caf  s, as well as at home and in some workplaces. Common practice in Viet Nam shows that alcohol is used to celebrate events, as part of socializing, to facilitate business and sometimes to drown sorrows, but also often used to have fun and enhance a good time. Therefore, the culture and social context for alcohol use is positive, perhaps unintentionally facilitating alcohol use among young people. Although under the law it is illegal to sell alcohol to young people below the age of sixteen, in the main this law is not enforced. A well known Vietnamese saying '*Nam vo tuu nhu ky vo phong*' is translated as 'a man without alcohol is like a flag without wind'. Such a saying reinforces drinking as an acceptable even expected part of life. While traditionally

**GRAPH 39 Drinkers ever drunk compared to never drunk**



women's alcohol use has not been regarded as acceptable, observation suggests that it is becoming increasingly more acceptable for women, including young women, to drink. This trend has also been seen in other Asian countries<sup>9</sup>.

### 7.8. Drinking Alcohol, Family Background and Peer Pressure

A notable finding of this survey, and related to parental behavior, rather than that of young people, is that 16.7% of youth reported that their father had a drinking problem or alcohol addiction (defined as getting drunk frequently, or drinking a lot very often). Almost one in five respondents in the 14-17 year old age group reported this to be the case.

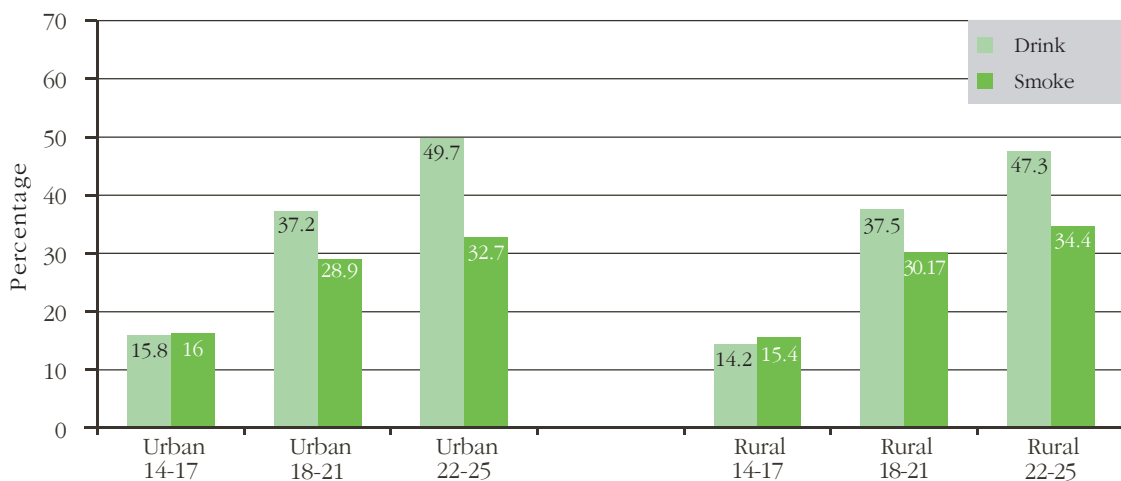
Young people were asked about the influence or pressure their peers exerted on them to drink. Young women generally reported very little peer pressure to drink, with the highest rate at only 3.7% for urban girls aged 22-25. Interestingly, for young men, alcohol was the area where peer pressure was reported to be at its highest compared to peer pressure for smoking, using drugs, having sex or viewing pornography. Peer pressure to drink increased with age, with almost half of the oldest group experiencing peer pressure to drink (see Graph 40). It has been suggested that peer pressure may be understood too simply as external pressure from peers to follow a certain behavior. More recent

theories about pressure on youth also acknowledge the internal pressure that young people experience to fit in, to look like TV stars, to be accepted by peers and to model desirable adult behaviors. Both external and internal pressure should be acknowledged when considering behavior change approaches<sup>10</sup>.

### 7.9. Drinking Alcohol and Associated Risk Behavior

It is of some interest and concern that the young men who reported to have been drunk two or more times in the prior month also engaged in a number of other risk behaviors, compared to those who had been drunk one or less times in the month prior to the survey. Young drinkers were asked about the frequency of their heavy drinking with the question: "How many times were you drunk during the last month?" Overall, youth reported to have been drunk 0.72 times in the last month. Rural 22-25 year old males were the most likely to have been drunk in the last month, with an average of 1.0 or once. Urban females were the least likely to report heavy drinking in the last month, across all ages; while the youngest and oldest girls reported an average of 0.26 times during which they had become drunk, young women in the 18-21 year old group reported only 0.33 times. However, these are only averages for the entire sample; there are, of course, a number of youth who reported to drink heavily on

**GRAPH 40** *Male Experiences of Peer Pressure to Drink and Smoke*



a number of occasions in the last month.

Heavy drinking or binge drinking has been clearly identified in international studies as well as recent injury research in Viet Nam as a social and health risk factor. A comparison between heavy or problem drinkers and non-problem drinkers found that heavy drinkers were more likely to have been injured as a result of violence outside the home (21.2%) compared to only 13.5% of non-heavy drinkers. Heavy drinkers were also more likely to

have smoked (78.6% compared to 46% who did not smoke). Among the single group, those who drank heavily were far more likely to have had sex (29.4%), compared with 10.2% of non-heavy drinkers. The heavy drinking group was also more likely to be involved in the risk behaviors of motorbike racing, participating in a group riot, injuring each other and carrying a weapon. Further and deeper analysis of young men's drinking and its interaction with other problems behaviors is needed.

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## Chapter 8

# Health Compromising and Problem Behaviors

Health-compromising behaviors (also referred to as risk or problem behaviors) include motorbike racing, violence, carrying a weapon, substance abuse, unsafe sex and self-harm. All of these issues were explored in this survey and some are discussed below. Issues of substance use and unsafe sex are reported elsewhere in the report.

## 8.1. Motorcycle Racing and Traffic Injuries

A question about participation in unauthorized motorcycle racing was asked, and a low 1.2% of the sample reported this behavior. However, most of the racing participants were male (2.3% compared with 0.3% for females). The highest risk-taking group, in terms of motorbike racing, is urban males aged 18-21 (5.3%).

A number of respondents had experienced at least one traffic injury (14%), with higher rates reported by urban young people at 26.6% than rural at 10.2%. These figures highlight a particular problem facing urban young people, with one in four reporting that they have had a traffic accident. This was again far higher in urban males (23.3%, 33.6% and 41.7%, increasing respectively with each age group).

Traffic injuries are the leading cause of death for young people aged 15-24<sup>1</sup> and risk-taking behaviors on roads and motorbikes, especially by young males, is seen as one contributing factor that puts young men and other people at risk.

## 8.2. The Experience of Violence

While the number of respondents who reported to have been injured as a result of violence in the home by a family member was low (2.2%), this rate more than doubled for ages 14-17 urban males (4.6%). There also seems to be gender differences

in family violence, with very small numbers of girls reporting to be victims of family violence at 1.5% compared to boys at 2.9%.

Nationally, 2.3% of respondents had carried a weapon, and this group mainly comprised of young males (4% compared to 0.5% of females). However, again the younger 14-17 year old and 18-21 year old urban males reported double the figures for carrying a weapon (6.4% and 9% respectively). This finding is consistent with a school-based study in Ho Chi Minh City that identified over 10% weapon carrying by young urban males<sup>2</sup>. Given the severity of injury that can be inflicted with weapons this 6-9% of weapon-carrying urban young men is not insignificant. Fewer than 3% of male respondents reported that they had injured someone enough for them to require medical attention.

While all young people reported having been injured outside the home at 8%, a rather high percentage of young males experienced this, and there may be some association here with weapon carrying and gang behavior in urban areas. While 2% of females had been injured, 15% of urban males aged 18-21 years and 15.7% of the same age in rural and ethnic groups reported injuries.

While 2.5% of young people reported that they had participated in a group riot, young males were the main players (4.7% compared to females at 0.5%). This increased to 8% for the 18-21 year old urban males. It should be noted that the reported violence figures may be lower than real figures because they included immoral and illegal behaviors of a kind that are always underreported.

While some of the percentages amongst the young urban male group may seem low, there appears to be a pattern of multiple risk behaviors within this group. A small group of urban young males may be at higher risk through their involvement in multiple risk factors including drinking, smoking, motorbike racing, carrying a weapon, and being involved in street violence and/or gangs. This area requires further research to better understand the real risks faced by this group of seemingly at-risk young men.

## 8.3 Self Harm and Suicide

An increase in mental health problems including



depression, self harm and suicide has been well observed and documented around the world over the past 20 years. Youth suicide became a major health concern in countries including New Zealand, Australia, Finland and Japan during the 1990s. Limited attention has been afforded to mental health in Viet Nam, although recently a suicide prevention conference included issues of youth<sup>3</sup>. In the present survey, a number of mental health questions were asked, including two about self-harm/violence. A total of 2.8% of respondents reported that they had tried to deliberately injure or harm themselves. The percentages were higher for young males; 6.4% for urban 18-21 year olds and 4.7% for the 22-25 age group. Rural rates for 14-17 year old females and 18-21 year old males were also higher than the average, at 3.3% and 4.1% respectively. Comparisons with Australia show that national self-harm figures for Vietnamese youth are lower at 2.8% compared with 5%<sup>4</sup>.

Respondents were asked if they had ever thought about suicide. 3.4% of the total sample replied 'yes'. Of note here is the higher percentage of young females reporting this seriously harmful thinking (6.6% and 7.8% of the 14-17 years and 18-21 years urban girls). Of the total sample, 0.5% or 42 young people reported to have attempted suicide. Some anecdotal evidence and hospital records suggest that suicide is a more significant cause of youth mortality and morbidity than SAVY suggests<sup>5</sup>. It is important to understand further these self-harm and self-destructive behaviors and thoughts, and consider what might be the contributing factors.

#### 8.4. Peer Pressure and Problem Behaviors

Respondents were asked about peer pressure, including positive pressure to avoid or resist behaviors such as drinking, causing trouble and watching pornography, as well as negative pressure to participate in such behaviors.

To a greater degree, reported peer pressure was 'positive' and 'protective', in the sense that peers discouraged negative behavior, rather than encouraging or inviting others into bad behavior. For all problem behaviors, between 65-75% of respondents reported that their friends encouraged

them not to participate in negative behaviors, or to maintain positive behaviors to avoid smoking, premarital sex and drugs. This is a very positive finding of the survey, and worth a deeper exploration in order to better understand how young people respond to such negative and positive pressures. It is especially important in assessing the appropriateness of peer education approaches as a continuing investment in these approaches to promote peer support among young people.

Some young males 18-25 years did report negative peer pressure, especially to smoke (28-35%) and to drink (37-50%). Only a tiny 1.2% of all respondents reported negative peer pressure to use illicit drugs. More urban respondents (8-12%) report some pressure to have premarital sex than rural counterparts (5.2-8.3%). 8.5-13% of young males reported peer pressure related to watching pornography and again this was the group aged 18-25, with higher urban figures. Young females consistently reported no negative peer pressure with percentages of less than 1%. This shows that the gender aspect might be protective, particularly for young females in relation to peer pressure for a number of problem behaviors that are examined in this section.

Adults often cite peer pressure as the reason for negative behavior, as sometimes do adolescents and youth. However the positive peer influence is often





ignored. Some authors advise caution in taking too simplistic a view of peer pressure, preferring to highlight the internal and media pressures that create a desire in young people to behave, dress or mimic their peers' behaviors, values and attitudes<sup>6</sup>. The psychology around peer pressure demands careful consideration including both the internal and external pressures that operate on young people. Friendships make up an important part of young people's lives and SAVY showed around 85% of young people have a group of friends they keep regular company with, be it friends of the same sex or a mixed group. A thorough understanding of the peer influence will help with intervention programs for young people.

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## Chapter 9

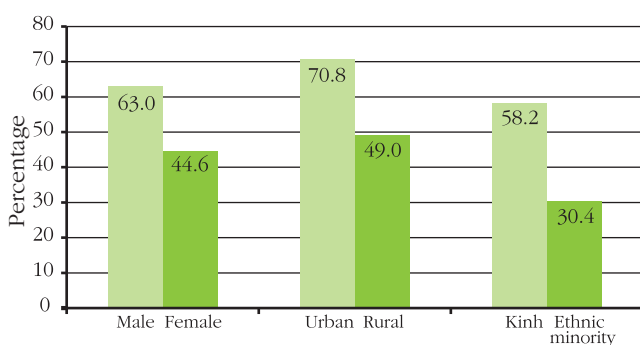
## Accidents, Injuries and Physical Harm

This section explores issues relating to accidents, injury and illness, including treatment and related use of health services. Given the high rates of deaths and accidents on the road, it was important that the survey determined information about young people and their use of motorbikes. A set of questions were asked to assess the risks of using motorbikes by asking whether the study respondents had ever ridden a motorbike, and whether they used a helmet while riding a motorbike and the reasons for not using it. Questions were asked about whether the respondent had ever had a traffic accident. An attempt was also made to ascertain what would make adolescents' comply with wearing helmets and whether their options matched with the existing intervention strategies that promote traffic safety and helmet use. Other than the history of traffic injuries, information was collected on morbidities due to general illness. Help and service seeking behaviors were also recorded relating to injuries and illnesses.

### 9.1. Motorbike Use

Nationally 54% of respondents had ridden a motorbike. However, Graph 41 shows marked differences in usage of motorbikes within the sample. More young men than young women ride motorbikes (63.8% compared to 44.6%). More urban young people reported having ridden a motorbike (70.8%) compared

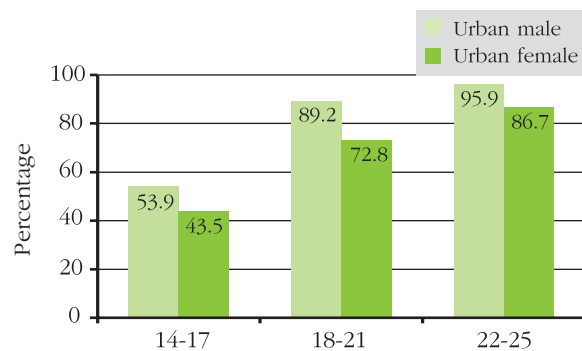
**GRAPH 41 Differences in Motorbike Use Between Groups of Young People**



to rural young people (49%). Far fewer ethnic minority young people have ridden a motorbike at (30.4%) compared to their Kinh counterparts (58.2%). These figures generally reflect the socioeconomic differences between urban, rural and ethnic groups.

As expected, experience with riding a motorbike increased with age, from 36.6% of the 14-17 year old group increasing to 67.1% in the 18-21 year old group and 70.5% of the 22-25 year old group. Graph 42 highlights the fact that motorbike use is a very common experience for the majority of urban youth. Of the youngest or adolescent group (14-17 years) 53.9% of young males and 43.7% of young females reported riding or being a passenger on a motorbike. The 18-25 age reported high rates of motorbike use and this echoes the much observed popular trend for younger boys and girls in urban areas to travel around on motorbikes, including going to school but often for leisure or as part of their social and dating behavior. Of note is that 95.1% of the urban 22-25 year old males and 86.1% of females reported riding a motorbike, highlighting just how common the experience (and associated risks) of riding a motorbike is for urban youth.

**GRAPH 42 Motorbike Use by Urban Young People**



### 9.2. Helmet Usage

Only 26.2% of young people reported usually wearing a helmet, either when driving or as a passenger on a motorbike. Helmet use increased progressively with age for both males and females in urban as well as rural areas (18.9%, 28.2% and 35.9% for each age group). This suggests that older young people in the sample might be slightly more aware of the risks of accidents and more committed to wearing a helmet than younger groups. However it could also reflect that older drivers (18-25) use the inter-provincial



roads more, where a legal expectation to wear a helmet exists. A most important finding (and a predicted finding) is that the majority of young people do not usually wear a helmet when riding a motorbike. This finding will not surprise an observer on the street in Hanoi or Ho Chi Minh City. Currently traffic accidents are the leading cause of death and serious injury for young people aged 15-19 in Viet Nam and the lack of helmet use unquestionably contributes to this.

Reasons often cited for not wearing a helmet include: cost, availability, discomfort, appearance and vanity, inconvenience of storage and impairment to vision among others. Anecdotal evidence suggests that the community may not be fully convinced about the protective value and effectiveness of motorbike helmets in reducing fatalities and the severity of injury. The fact that helmets can save lives is often disregarded, even refuted by young and adults alike. One of the challenges for public health campaigns (in this complex area) is to convince people of helmet efficacy. SAVY findings do however provide some very clear insight into why young people do and do not wear helmets.

Respondents (both those that did, and those that did not wear a helmet) were asked about factors that influenced use or non-use of a helmet. As three quarters of the sample didn't usually wear a helmet when on a motorbike, the majority of young people responded to the question: "What factors would influence you to wear a motorbike helmet in the future?" Six factors were explored, with the option to identify multiple factors. They included legislation, requirement by the school, physical comfort, mass media campaigns, personal experience of death and injury, and cost/free helmets. A perhaps unexpected finding was that only two significant factors were reported. The first and most common reason influencing helmet use behavior was a legal obligation (including enforcement) at 51.9%, and the second most common factor was hearing about accidents and deaths or having personal experience of a serious accident (37%).

Worthy of note is that a number of intervention strategies, previously and currently promoted through traffic safety and helmet use campaigns, were ranked very low or ignored by young people. These included media campaigns (4%), requirement by school (0.9%), easy to wear/attractive helmets (0.8%) and free

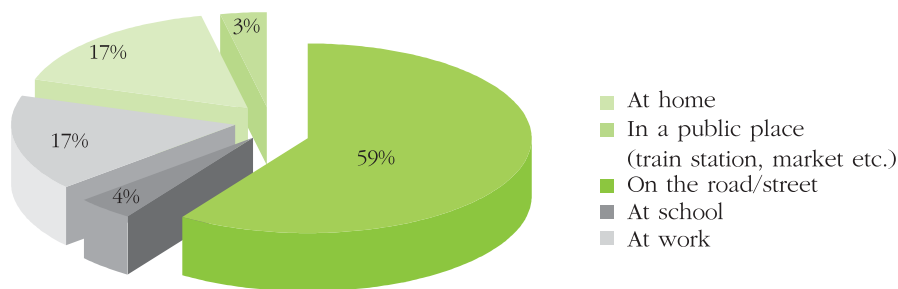
helmets (0.3%). This finding highlights the importance of a supportive legislative and policy environment (and policing of such legislation) as the first step in changing young people's helmet wearing behavior. It also suggests that consideration of scare tactics and fear campaigns may be an appropriate and effective way to reach young people with traffic accident messages. Scare tactics approaches have been used with some success in mass media campaigns in other countries. However, these have had the greatest success when coupled with legislation and policing<sup>1</sup>.

### 9.3. Unintentional Injury Requiring Treatment

Young people were asked if they had any unintentional injury in the prior twelve months that had required medical treatment. 7.4% of the total sample reported some unintentional injury in the prior year, but this was 11% of young men and only 3.7% of young women. The highest reported accident/injury rate was 16.9% in urban men aged 22-25. The group reporting to have had an accident was asked: "Where did the accident/injury occur"? By far the most likely place for young people to have been injured was on the road (59.8%). Accidents also took place at work and at home (both 16.7%). For Vietnamese young people the roads are a high risk setting for accidents compared to other places. This is not surprising given the previous figures about motorbike use.

### 9.4. Traffic Accidents

Young people were specifically asked if they had ever had a traffic accident (regardless of severity level). 14% of respondents had experienced at least one traffic accident in their life with far higher traffic accident rates by urban young people (26.6%) compared with rural (10.2%). Males were also more likely to have had an accident than females (17.8% compared to 10.4%). In ethnic minority groups only 7.2% reported having had a traffic accident. An interesting pattern emerges for the traffic accidents of urban males, which are far higher than overall totals and increase respectively with each age group (23.3%, 33.6% and 41.7%). This is explained by the over representation of urban males aged 18-25 years that ride motorbikes. In addition, older respondents are likely to have been driving for more years than younger counterparts and thus have been exposed to the risk of accidents for a longer

**GRAPH 43** *Where Accidents Take Place*

period. About one in five urban young females across ages have experienced a traffic accident. SAVY findings suggest that traffic accidents pose a major risk for the health of urban young people.

For the 14-17 age group, nearly three times as many urban young people experience traffic accidents than their rural counterparts. Many of these young people are in school and this creates opportunities for targeted interventions in the school setting. However, lessons from other countries caution that well-planned campaigns (and enforcement of existing legislation) should not be neglected in search of a quick-fix solution.

Traffic injuries are the leading cause of death for young people aged 15-24 in Viet Nam and prevention of accidents and interventions to reduce risk-taking behaviors on roads, especially by young males have received some attention<sup>2</sup>. Estimates suggest that traffic injuries will increase rather than decrease in coming years, and preventing and protecting young people from being over represented in these figures remains an urgent and immediate challenge. Risky and reckless driving, motorbike racing, alcohol use, poor roads, increased traffic density, limited legislation and

limited policing can all be seen as factors contributing to the unacceptable numbers of deaths and disabilities from traffic accidents.

Countries like Australia and Canada have implemented special restrictions and requirements for young drivers as part of public health measures to protect young people. These include no drinking and driving, special speed restrictions for young drivers, and extensive driver training. The social aspects and role of the motorbike in urban dating and relationships appears to be a special Vietnamese phenomenon that puts young men and women at ongoing risk. Riding a motorbike is increasingly seen as an indication of wealth and, as more families can afford motorbike(s), the chance for young people to access and use motorbikes will increase, as will the chance of injury.

## 9.5. Illness

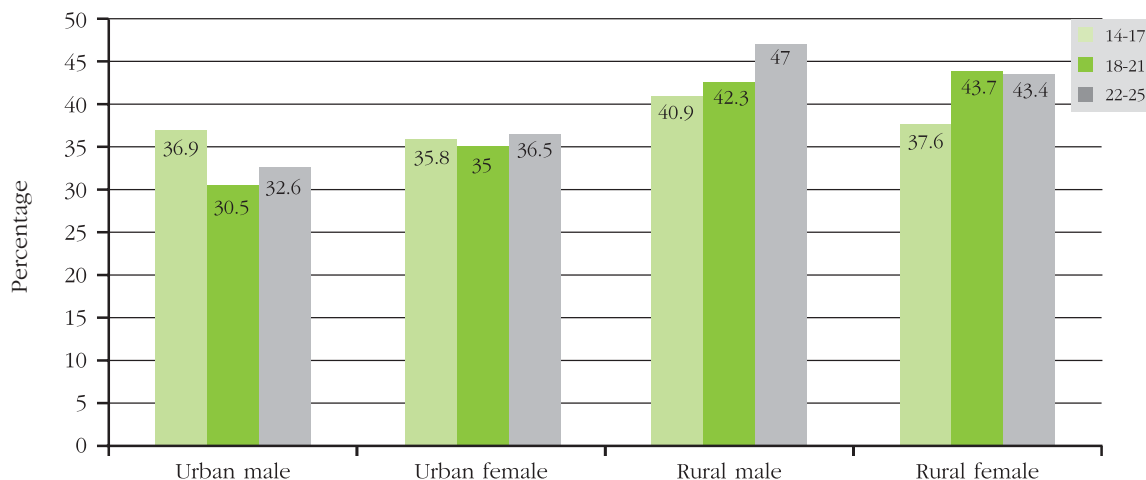
Young people were asked, “Have you ever been too sick to go to school or work in the last 12 months?” Of the total sample, 39.7% reported an illness-related absence from work or school at least once in the prior twelve months. As shown in Graph 45A, illness was more common in rural males (40.9-47%) compared to urban males (30.5-36.9%). Similarly rural females reported more illness-related absence (37.6-43.7%), compared with urban young women (35-36.5%).

Disaggregated by ethnicity, the rates of illness, in all age groups, are higher for ethnic minorities at 51.5% compared to the Kinh at 39.4%. With regard to geographic regions, the highest rate of illness is reported in Central Highland (50.6%) and lowest in the North Central region of Viet Nam (35.2%)

When analyzed for economic status as seen in Graph 45B the data show that the rate of illness in the last 12

**GRAPH 44** *Ever Had Traffic Accident: Urban and Rural Youth Comparisons*



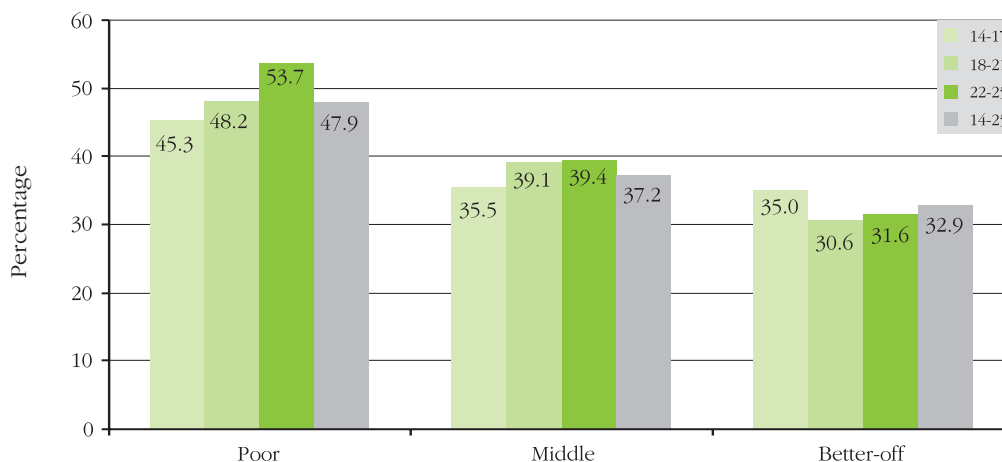
**GRAPH 45A** *Too Sick for School or Work In The Last 12 Months*

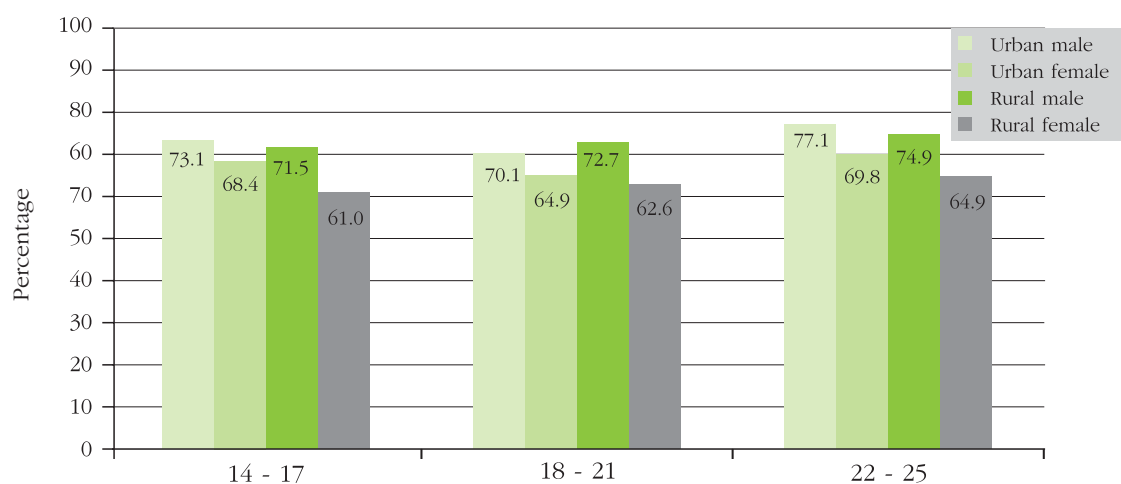
months prior to the survey decreases as economic status increases. In general, only 32.9% of adolescents in the “better-off” group reported sickness within the last 12 months versus 47.9% in the “poorest” group. This difference also exists in all age groups: 14-17, 18-21, and 22-25.

Young people were asked if they had sought medical treatment in response to their most recent illness/accident. Note that the definition of medical treatment included any medical treatment, not just specifically attending a medical service. The majority did seek medical treatment with their most recent illness or injury (68.2%). 9% more males than females sought medical treatment at 72.7% males and 63.6%

females. Graph 46 shows a common gender difference, with higher percentages of young men seeking help in each and every comparative group in the range of 4.7% to 10.3%. For example, in the 22-25 age group 77.1% males compared to 69.8% females sought help; in their rural counterparts, 74.9% of males and 10% less females, at 64.9%, sought help. Young people from ethnic minorities were a little more likely to seek medical treatment for an accident/illness or injury, at 72.4% compared with Kinh at 67.4%.

Of those who reported not to seek medical help by far the most common reason was that the condition was not serious enough (95%), with 2.5% reporting that they did not have enough money.

**GRAPH 45B** *Reported Illness in the Last 12 Months by Economic Conditions or FMC*

**GRAPH 46** *Percent Seeking Medical Help During Most Recent Illness*

## 9.6. Medical Services

Respondents were asked about where or how they access medical treatment. Table 9 shows similar patterns between groups for self-medication. However urban respondents are far more likely to use higher level services, including provincial services that are perceived as better quality, than rural counterparts when accessing the health system.

The large majority (70%) reported to have bought medicine for self-treatment. This SAVY finding is consistent with prior surveys and research showing self medication is by far the most common practice in Viet Nam in all income groups.<sup>[3,4]</sup> This finding supports the fact that young people are similar to adults in their patterns and practices relating to self-medication.

A little over a quarter of young people, at 27.4%, sought medical support from a private clinic, with the highest percentage of private service use by adolescent (14-17 years) urban males (40%) followed by 18-21

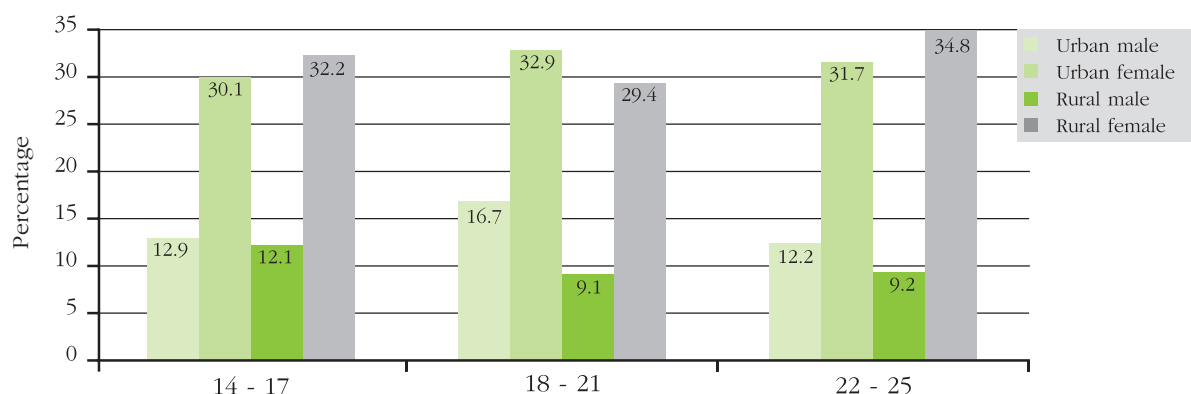
rural males (32.1%). Only 11.3% of ethnic minority counterparts accessed private health clinics compared to 30.3% of Kinh. This may reflect the more limited availability of private health services in more remote ethnic minority areas, as well as financial limitations in accessing private care.

Similar numbers of respondents reported seeking medical treatment from the commune health centre (26.7%) as they did for private services. There was a marked difference though in urban and rural use of commune health services. Graph 47 highlights the low usage of commune health centers by urban respondents. Rural males and females are far more likely to use commune health centers than their urban counterparts. Figures across the three age groups for females show 32.2%, 29.4% and 34.8% in rural areas compared to 12.1%, 9.1% and 9.2% in urban areas.

Numerous reasons have been reported for use and non-use of health services including costs, accessibility of service, severity and nature of health issue,

**TABLE 9** *Sites Accessed for Medical Treatment*

Type of Medical Treatment	Urban	Rural	Male	Female	Kinh	Ethnic minority
Self-medicate	71.1	69	72.6	66.1	69.6	69.2
Commune health Station	12.4	31.5	27.2	26.3	22.4	51.4
Private provider	28.4	27.1	30.4	24	30.3	11.3
District centre	19	19.1	20.7	17.1	19.4	17
Province	18.2	8.2	12.1	9.2	11.8	4.7
Traditional medicine	0.8	2.7	2.3	2.2	1.8	4.7

**GRAPH 47 Commune Health Center Usage by Urban and Rural Young People**

confidence in the commune health service provider and perceptions about quality of services. Recent research that focused specifically on youth perspectives of health services identified many of the same issues, with privacy and confidentiality of service a top priority for unmarried youth and the technical competence of the health care provider also a priority<sup>5</sup>.

Just fewer than one in five people (19%) reported attending the district health centre, with 10.7% reporting attendance at the provincial health centre. Again differences can be seen with ethnic minority young people where only 4.7%, compared with Kinh at 11.8%, reported to have accessed provincial health services. A relatively small number (3.6%) reported seeking medical support from the school health service, although this was higher for the youngest group 14-17 at 5.2%. Only 2.2% of young people reported use of traditional medicines, suggesting this is not a popular or preferred mode of medical treatment

for young people.

The lower use of commune health centers in urban areas can also be explained by the tendency of urban people to go to district and provincial hospitals for treatment. This has also resulted in increasing numbers of patients, who could have been treated at commune or even district facilities, overcrowding provincial services. In remote rural areas, especially ethnic minority areas, the distance to district and provincial facilitators has probably promoted the utilization of commune health services.

## 9.7. Symptoms and Recent Illness

41% of the sample reported illness symptom(s) in the prior month with no difference between the urban and rural groups,. There is a notable difference however between females (45.8%) and males (36.5%) reporting illness symptoms. The youngest females in urban areas

**GRAPH 48 Percentage of Reported Illness Symptoms in the Last Month**

**TABLE 10** *Most Frequently Reported Disabilities and Disease*

	Total figures	Male	Female	Ethnic minority
Digestive	5.6	5.3	6.0	6.8
Vision	4.8	3.9 14-17 urban 13.6%	5.7 14-17 urban 20%	0.9
Goiter	3.2	1.1	5.4	6.8 Male 2.5 Female 10.9
Cardio vascular disease	2.4	2.2	2.5	2.5
Asthma	1.9	2.1	1.7	3.6
Respiratory	1.9	2.4	1.4	4.0

(47.8%), followed by the youngest females in rural areas (45.8%) were more likely to report illness symptoms.

### 9.8. Disease and Disability

Young people were asked whether they suffered from, or had ever suffered from, a range of diseases and disabilities. Therefore the disease and disability data is reported but not diagnosed, as SAVY did not include any medical examinations. These results may therefore differ from other reports. However this data should not be dismissed as it does provide a picture about young people's general feeling about their physical health. The five most common symptoms reported, in order, were fever, common cold, stomach ache, respiratory problems and diarrhea. Table 10 highlights the burden of symptoms experienced by Kinh compared with ethnic minority young people in the month prior to the survey.

Young people were also asked about any on-going illness they suffered, but again this was not diagnosed. A list of twelve illnesses was provided. The listed illnesses included asthma, cardiovascular disease, vision problems, goiter, tuberculosis, cancer and curvature of the spine, among others. Table 10 presents the results from the six most commonly reported disease and disabilities. Digestive problems were the most commonly reported disease across all groups of young people. Researchers suggest that this is linked to quality of food. Many young people will eat street food, or food prepared with inadequate attention to food safety, resulting in stomach and digestive problems.

Vision problems seem to be greatly over represented in the youngest urban groups (14-17 years), with young women reporting vision problems at 20% and young boys at 13.6%. This is a much higher rate compared with the 2.4% of rural young women and 1.7% of rural young men of the same age group. The reasons for such an urban/rural disparity may include an increase by urban young people of hours of studying, spending more time inside, watching TV and playing computer video games, and greater access to optometrists and greater available resources to allow for screening services in urban areas.

A goitre, or enlarged thyroid gland, was reported by 3.2% of respondents. However, young women were more likely to report goitre particularly young women from ethnic minority areas (10.9%). Goiters could be linked to thyroid diseases and or a lack of iodine. Without diagnostic testing, no confirmation of the cause of reported goitres is possible.

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## Chapter 10

## Mental Well-being, Aspirations and Expectations

A number of questions and statements were included in the questionnaire to explore young people's perceptions about themselves, self esteem, feelings of worth and their outlook and dreams for the future. In general SAVY indicates that young Vietnamese have a positive outlook toward the future, have high expectations, value themselves and feel valued by family. They remain connected to family in a way that is protective. While they tend to feel that they have a voice and are usually listened too, they also see a role for greater participation in the society. These results do however indicate that some young people feel alone and worry about the future and that, as many as one in five have previously felt helpless and hopeless about the future. Clearly some young people see a better future than others, and those living in more difficult circumstances now see their future reality as less positive than those who are better off.

### 10.1. Positive Self Assessment

Five statements were presented to young people in order to assess their feelings about their own self worth, personal qualities and value to others. This set of questions required an agree/disagree response that was scored to correspond to whether candidates completely agreed, partly agreed, disagreed or did not know. Each positive response was given a score of 1 and each candidate then received a positive self-

assessment score ranging from 1-5.

In general, young people attained relatively high scores, averaging 3.5 across all groups, with a score of 3.4 for ethnic minority young people. Overwhelmingly, this survey shows that respondents felt valuable to their families with 94.7% agreeing, either fully or partially, that they felt valuable. Similarly high numbers of respondents were very positive about the statement I have some good qualities, with 98.4% (63.2% fully and 35.2% partially) agreeing with the statement. Respondents also generally agreed with the statement I believe I can do what others can (71.3% agreeing completely and 22.6% partially agreeing). The analysis shows very similar figures from Kinh compared to ethnic minority young people on many variables.

Statements posed in a negative way (Sometimes I feel I am no good, for example) indicated more negative feelings than those for positive statements. But even so, many respondents disagreed, or partially disagreed, with negative statements about their self-esteem, which they generally regard as being positive. In response to the statement I am not proud of myself only 24.4% completely agreed, with 42.6% partially agreeing and 33.2% disagreeing (thus indicating that 75% are to some degree proud of themselves). In response to the statement Sometimes I think I am no good at all, 31% reported negative feelings about themselves, with the others disagreeing or only partly agreeing (69%).

Overall, the number of young people reporting a fully negative response about themselves ranged between 2% and 31%. This includes either disagreeing with a positive statement or agreeing with a negative statement. Further analysis of these variables is necessary in order to understand this group of young people with low self-esteem who, according to research, are more at risk for a number of health

**TABLE 11** *Self-perception Statements by Gender, Location, and Ethnic Minority*

Self perception Statement	Male	Female	Urban	Rural	Ethnic Minority
I have some good qualities	99.7	98.1	98.8	98.2	97.9
I am not proud of myself	24.1	24.4	19.9	25.6	24.6
I can do what others do	94.8	93.1	94.2	93.9	92.2
Sometimes I feel I am no good	30.5	31.8	30.7	31.3	30.7
I think I am valuable to my family	95.9	93.8	93.9	95.1	95.7



compromising behaviors<sup>1</sup>. The factors and reasons for low self-esteem have been extensively studied and appear to be numerous and complex, with inter-relationships between and within factors. For example a young person having trouble coping academically may feel rather negative about school or about themselves or about both. A young person living in a family with conflict may be doing well but may feel upset and negative because of their home life. A young person may feel sad or down on a particular day only as a result of hormones or the pressures of transition to adulthood. While some sadness has been identified as normal in terms of mental health issues, young people's resilience and ability to cope are issues predicted to be future, and maybe emerging, issues for young people in Viet Nam. Thus, there is an urgent need to understand the interaction and the dynamics of the connections between different related variables.

## 10.2. Positive Expectations

Participants were presented with an additional four statements about their expectations of jobs, family life and income. Using the agree/disagree method of response, each person was given a score between 0-4. The overall score was 2.8, with the lowest among ethnic minority young people (2.3) followed by the 14-17 rural girls (2.4) and the 22-25 urban and rural males who recorded the highest average score of 3.2. Overall males (3) report higher expectations than females (2.6), with Kinh young people scoring a little bit higher than their ethnic minority counterparts.

The degree of positive expectations seems to increase with age, irrespective of sex or urban and rural differences. One hypothesis is that, with increasing age, young people are closer to the job market and incomes, have more experience about family life and therefore have more positive expectations of life. The younger or adolescent years between the ages of 14-17 are generally characterized by more physical changes, and this may also bring greater insecurity and uncertainty, or the 'roller coaster' effect (mood swings) that is sometimes identified during adolescence. If this is the case in Viet Nam, young people may benefit from additional guidance, general resilience and coping skills, and counseling and supportive emotional environments. Some who experience extremes of



**GRAPH 49 Positive Expectations Scores by Age Groups, Age and Gender**



**TABLE 12** *Percentage Fully Agreed with Positive Expectations by Gender, Location and Ethnic Minority*

Positive Expectations	Male % Fully Agree	Female % Fully Agree	Urban % Fully Agree	Rural % Fully Agree	Ethnic Minority % Fully Agree
I will have a happy family in the future	86.7	78.2	81.0	83.1	80.3
I will have a job that I like	80.0	74.8	78.2	77.2	76.4 Male 64.2 Female
I will have the opportunity to do what I want to	80.0	72.6	77.9	75.9	67.4
I will have a good income in order to live comfortably	64.1	53.6	59.9	58.7	58.8 43.5 Female

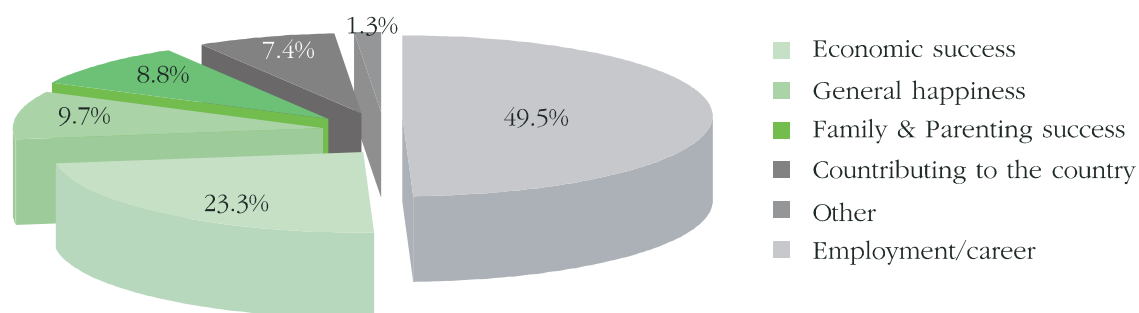
sadness or mental health problems may require more specialized interventions.

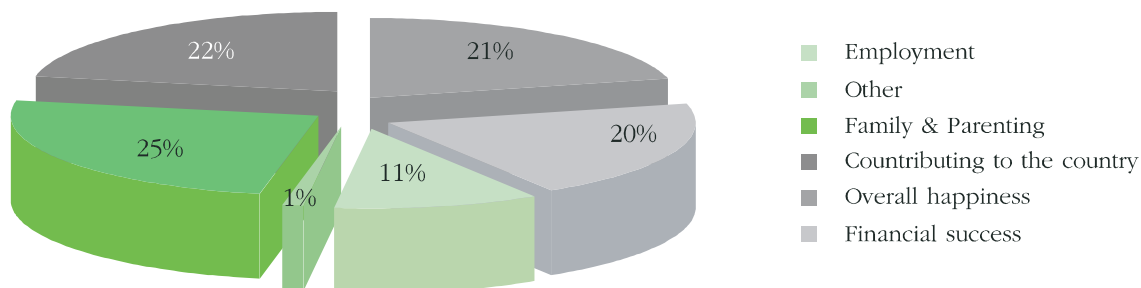
Most young people reported positive expectations about future family happiness, with 82.6% of respondents completely agreeing with the statement “*I will have a happy family in the future*”. Young men (86.7%) were even more positive than young women (78.2%). In response to the statement “*I will have a job that I like*”, 77.4% of respondents fully agreed, with another 20% partially agreeing. Ethnic minority young women were the least positive of all groups with only 64.2% being fully optimistic about liking their future work. Similar levels of agreement were reported for the statement “*I will have the opportunity to do what I want to*”. These differing levels, or perceived levels, of future happiness might reflect the current job market situation as much as it does personal goals or values.

Responses were not as positive to the statement “*I will have a good income in order to live comfortably*” with only 59% completely agreeing; again young men

(64.1%) were more positive than the young women (53.6%). There is a difference here between young people from Kinh (59%) and young people from ethnic minorities (51.1% overall and 43.5% for women). This is not surprising as SAVY results clearly show that while 35% of Kinh families have high family material conditions (FMC), only 7.4% of ethnic families report high FMC. Clearly the reality for many young people from ethnic minority families is that of a hard life and, while remaining positive about opportunities for family happiness, they are understandably less optimistic about their economic futures.

Of interest is the response to a question posed regarding young people’s economic outlook by the end of 2006. 71.6% of respondents fully agreed that they would be better off economically in 2006. Again ethnic minority young people were less likely to fully agree (63.1%). 26.1% of the total sample were neutral and a small 2.5% were pessimistic, suggesting they would be worse off.

**GRAPH 50.** *Most Important Aspiration for Future*

**GRAPH 51** *Secondary Aspirations for Future*

### 10.3. Future Aspirations

Young people were asked about their aspirations for the future and invited to identify a maximum of two aspirations. Graph 50 shows in terms of their first or highest priority, half of the sample (49.6%) listed employment as their first aspiration, with another 23.3% aspiring to economic and financial security. Only 9.7% aspired to general happiness, with an even smaller percentage aspiring to family and parenting success (8.8%, similar for males and females). Overall, 7.4% of respondents identified making a contribution to the country as their highest future aspiration, with this being more common in younger members (11.6% for the 14-17 age group, moving down to 5.1% for the 18-21 group and 2.4% for the 22-25 groups). Of some interest, illustrated in Graph 51, is that 22% of respondents selected contribution to the country as their second aspiration, again with higher rates in the younger groups (14-17 age group at 28%, down to 18.5% in 18-21 age group and 15.2% in the oldest group of 22-25).

Young people's second priorities were more varied with economic/financial security first (25.0%), followed by contribution to the country (22%), overall happiness (21%), family and parenting (20%) and lastly employment (11%). SAVY indicates that employment, income and financial success are of highest priority to the future aspirations of most young people, and that issues of family and happiness are reported to be in second place.

### 10.4. Comparison to Parents' Lives

Respondents were asked a rather broad and general question to compare their own lives to that of their parents, and to predict if their life would be either

much better, better, about the same or worse. No specific criteria to define the 'betterment' of their lives was given. 87.5% of respondents expected that their lives would be much better than their parents. This was a little lower for ethnic minority young women (81.2%). 12% of the sample believed their lives would be similar to their parents, with less than 1% expecting it to be worse. Many Vietnamese parents have great expectations for their children, and also expect their children's lives and achievements to exceed that of their own. Such expectations can create a desire and motivation to achieve, internal and external pressure for young people to succeed, intense involvement in young people's lives by parents and in some cases a feeling of obligation by young people to follow the dreams of their parents<sup>2</sup>.

### 10.5. Young People's Suggestions for Government

Respondents were invited to suggest actions that the government could take to improve the lives of young people. They were asked to suggest two separate actions and make one their first priority and the other their second priority. Table 13 presents data on the first and second priorities. Prior to the survey there was some question as to whether young people would answer this question. However 98% of all respondents provided a response.

The most commonly identified first priority was that of increased opportunity for work (40.5%), followed by increased opportunity for education (28.6%). An even greater percentage of the older respondents, 22-25 years, listed opportunities for work as the number one priority (44.8%). Of note is that only 8.5% of respondents suggested improved health services, with urban males 14-17 years reporting the lowest at 4.2%.

**TABLE 13** *Suggested Government Actions*

Suggested Government Action to Improve Lives of Young People	Ranking of Actions Priority One		Ranking of Actions Priority Two	
	Proportion	Ranking	Proportion	Ranking
Increase access to opportunities for employment/work	40.5%	1	21.0%	2
Increase educational opportunities	28.6%	2	9.1%	5
Increase access to youth health services	8.5%	3	8.6%	6
Allow greater involvement and participation in the community	8.4%	4	22.2%	1
Provide more support to families	7.0%	5	19.7%	3
Develop/provide more policy and legal support	3.7%	6	11%	4
More leisure facilities	3.0%	7	8.1%	7

This may be because issues such as employment are far more important in terms of economics, or because the majority of young people are apparently healthy and do not need to use health services. However the absence of health services can have major consequences for some groups (especially pregnant young women, accident victims) in emergencies.

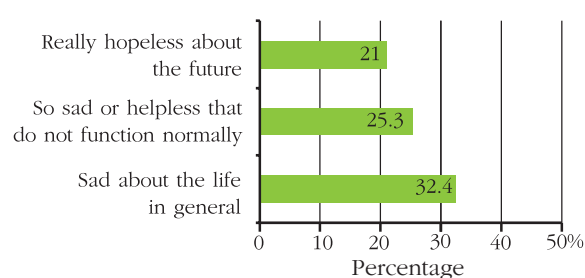
A different trend can be seen in the respondents' second priorities, where young people gave a variety of responses to a range of suggested government actions. The most commonly identified action was opportunities for greater participation in the community (22.2%), followed closely again by work (21.0%). The provision of more support to families resulted in a similar percentage (19.7%).

Interestingly young people did not generally list leisure facilities as a priority; only 3% listed it as their first priority. This does not necessarily mean that leisure facilities are adequate but perhaps indicates that young people are concerned about major and fundamental issues, such as work and education, rather than what they may regard as the luxury of enjoyment or exercise. The preventive health and social benefits from participating in leisure pursuits have been well documented elsewhere and should not be ignored when considering the protective and positive factors that could be further encouraged for young people<sup>3</sup>.

## 10.6. Mental Attitude Toward the Future

A number of questions were asked relating to coping, feelings of sadness and depression, and young people's feelings about the future. Three questions provided a positive outlook score, which could range from 0 to 3. The overall average score was 2.2, with scores ranging from 1.9 for the 18-21 urban females and 2.4 for 14-17 rural boys. It should be noted however that average scores for this question were very similar. Table 13 however shows specific responses and differences for each question.

The overall responses indicate a rather positive outlook, suggesting that the majority of young Vietnamese people are resilient and cope with life's day-to-day worries and challenges. Other survey

**GRAPH 52** *Ever Felt Sad, Helpless, Hopeless...*

indicators suggest that they are generally hard working with high goals, strongly connected to their family and ambitious. There is however another group of as many as one in five who report to have felt really hopeless about their future at some stage. Graph 52 illustrates that about one third (32.4%) of young people have, at some stage, felt sad about their life in general. While periods of sadness for a short or defined period of time are not necessarily problematic, there were another 25.3% that reported to have felt so sad or helpless that they ceased doing their normal activities, finding it difficult to function. This included slightly higher percentages of females than males, and as many as 34% among ethnic minority girls. 21% reported that at some stage they have felt really hopeless about the future and this figure is slightly higher among ethnic minority young people (25%).

WHO predicts that mental health problems and mental illness will be a leading burden of disease by the year 2020<sup>4</sup>. Anecdotal reports, extensive media coverage and even the MoET have recognized stress and mental health problems as an increasing issue for young people.

### 10.7. Feelings about Voice or Opportunity to Participate

A few questions explored the opportunity for young people to participate including having a voice at school, and within their families and local community. In general young people reported that there were avenues and opportunities to provide opinions and participate in decision-making, especially at school. The majority of young people (67.5%) felt that their family valued what they had to say, and young people reported that they felt that they could 'do' (achieve)

whatever they liked. Young people tend to value these opportunities to participate, with 22.2% suggesting that increasing opportunities for young people to participate could be one role for the government (priority 2) and 8.4% (priority 1).

Interestingly, older respondents 22-25 years, were more likely to agree that they were listened to by their family (77.2%) compared with the youngest group aged 14-17 years (64%). This may reflect the fact that older young people have better communication skills, or it may reflect that younger adolescents are less likely to be taken seriously or listened too, a rather different scenario. A 13-country UNICEF study<sup>5</sup> also found Vietnamese youth to be some of the most listened to youth in the region, as well as youth who have more opportunities and the ability to express their opinions, compared with other countries in the region.

1. Costa FM, Jessor R, Turbin MS, Dong Q, Zhang H, Wang C; University of Colorado. Institute of Behavioral Science Research Program on Health Behavior. The Role of Social Context in Adolescence: Context Protection and context Risk in the U.S. and China. *Applied Development Science*; 2004 Sep. In Press
2. PATH US. Adolescent Boys, Sexual Health and Health Care in Viet Nam – a need assessment in Ba Dinh and Tu Liem Districts. Hanoi; 2002. Unpublished.
3. CDC. Youth Risk Behavior Surveillance- United States 2001 Morbidity and Mortality Weekly Report. 2002 Jun; Vol 51.
4. WHO. World Health Report 2003 - Shaping the Future. Geneva; 2003.
5. UNICEF Regional Office for East Asia and the Pacific. Speaking Out! Voices of Children and Adolescents in East Asia and the Pacific – A Regional Opinion Survey. Bangkok; 2001.





## Chapter 11

## Risk and Resilience Factors

One of the newer approaches to the prevention of young peoples' problem behaviors is the risk and protective factors approach, previously discussed in the introduction to this report. The process of identifying risk and protective factors must include an understanding of adolescents' social relationships as they experience developmental changes in their physical, social and psychological selves. Such relationships will vary depending on the social and cultural contexts of the setting. Risk and protective factors in SAVY must therefore be considered and understood from a Vietnamese social and cultural context.

Generally, risk and protective factors are grouped under four important areas of daily life: the family, the school, the community and within peer groups and individuals. For the SAVY analysis we have included a number of measures that have been identified by existing literature as risk and protective factors.

From the questions asked, a number of different scales were created including: positive self-image; positive family situation; positive outlook including current and future optimism; positive attitude and connection to school; and presence/absence of violence indicators.

### 11.1. Family Connection as a Protective Factor

A series of eight questions were used to assess the family situation or measure the level of young people's connection to family. Each young person received a score from 0-8, with zero indicating a negative or low connection to family and 8 indicating a very positive family situation. For comparison, respondents were divided into two groups. The first group, with the lowest scores, was classified with elevated family risk factors (40%) and the second group, with the highest connection scores, classified as elevated family protective

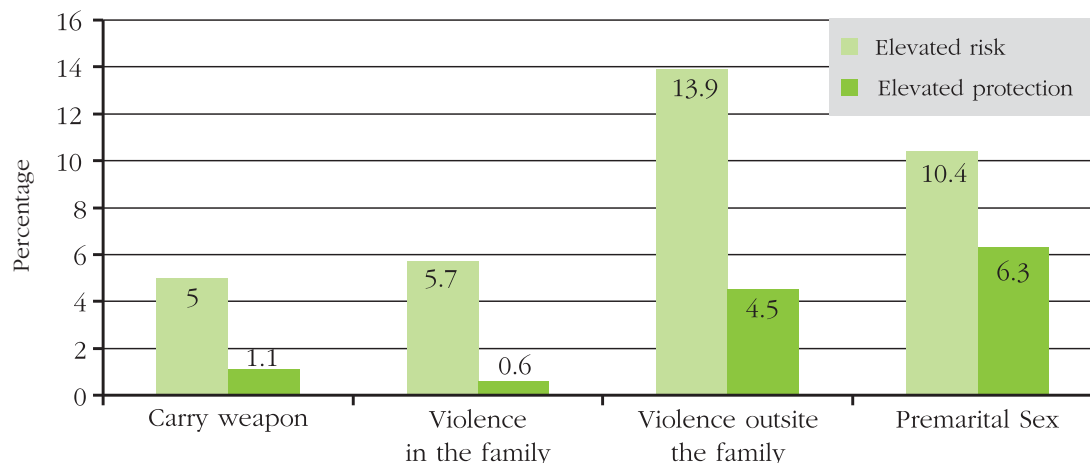
factors (31%). Analysis was carried out to look at the differential between the two groups for a number of problem behaviors, including not wearing a helmet, premarital sex, alcohol use, suicide ideation and involvement in violence<sup>1</sup>.

Among the married respondents, 22.5% of those with elevated family risk factors compared to 13% of those with elevated family protective factors reported to have had premarital sex. A very small difference can be seen in relation to alcohol use between the two groups, with 50.3% of those in the elevated risk factors group reporting ever to have had a drink compared to 45.7% in the elevated family protection group. It might be more useful in future to look at family risk and protective factors in relation to heavy drinking, rather than to the ever had a drink group, as it is questionable whether using alcohol in moderation is a problem behavior currently in Viet Nam.

Nationally the percentage of young people injured as a result of violence within the home was 2.2%. Those young people with elevated family risks scores were more likely to be injured within the home (3.8%) than those with a high family connectedness score (a very low rate of 0.7%). While differences are modest, again those with highest family connectedness reported lower levels of being injured as a result of violence outside the family home (5.7%, lower than the national average of 8%) compared with 9.3% for young people with elevated family risk factors. A pattern of protection can also be interpreted for those with elevated family connection in relation to mental health. Young people with elevated family risk were more likely to have had suicidal thoughts (5.4% compared with the national mean of 3.4%) and far more than respondents with elevated family protective factors (1.5%). While further analysis is required to better understand these risk and protective factors in the Vietnamese context, research from around the world – including China, the United States, Australia and Europe – has shown that:

*Independent of race, ethnicity, family structure and poverty status, adolescents who are connected to their parents, to their families, and to their school communities are healthier than those who are not<sup>2</sup>.*

One hypothesis for the seemingly positive results from SAVY could be that strong and intense family

**GRAPH 53 Positive Outlook and Risk Behaviors**

connections, which are part of Viet Nam's history and culture, may already be operating as a protective factor in relation to a number of behaviors for young people.

### 11.2. Positive Outlook/Optimism as a Protective Factor

Questions contributing to the positive outlook scale dealt with personal issues of optimism/pessimism about the future and included experiences of sadness, depression and perceived ability to cope in difficult times (resilience). Those young people (20%) whose scores were lowest (reflecting least optimistic, lesser coping capacity and lower self concept) were classified as being at elevated risk for this factor. Those young people with the most optimistic outlook and highest scores (about 30%) were classified as having elevated protection for this factor. A number of differences can be seen between the two groups of elevated risk and elevated protection.

In relation to suicide ideation a significant difference can be seen between the two groups, with a high 10.9% of those with elevated risk factors (3.4% of all respondents) reporting to have thought of suicide compared to a much smaller 0.4% for the most optimistic/elevated protective factors group. Similarly 6.7% of the elevated risk group had tried to injure or harm themselves compared to 1.3% of the group with elevated optimism and a more positive outlook. Those with

elevated risk factors were also more likely to have carried a weapon, been injured in the home by a family member, be a victim of violence outside the home, as well as more likely to have had premarital sex. While optimism and positive outlook can be seen as individual traits that cannot be changed, significant work has been done looking at the building of personal optimism, positive self talk, teaching resilience skills and creating environments that help young people be more optimistic and resilient<sup>3</sup>.

### 11.3. School Connection

Young people were asked a series of eight questions which gauged their feelings towards school, including attitudes towards study, attitudes to school attendance, encouragement and treatment from teachers, and opportunity to give opinions in school. Each young person received a score from 0-8 indicating the level of school connection.

Using a similar process as previously outlined, the young people with the lowest school connection score (30%) and highest school connection score (33%) were compared for their involvement with a number of risk behaviors. The group with elevated school risk factors were disciplined more than those with elevated protective factors (6.2% v 3.8%). Those with lower connection to school were more likely to have injured themselves (4.3%) than those with the highest connection to school (1.7%). Smoking was observed among 14.8% of young people with elevated risk or low school connection

compared with 10.9% of those with elevated school protective factors.

also indicate the significance of risk and protective factors.

## 11.4 Family Conflict

Family conflict, defined as remembering frequent quarrels, was reported by 8.9% of the total sample. Of those young people living in families with ongoing conflict 26% reported having a father with an alcohol addiction. This was much higher than the young people reporting no conflict, with 14.6% reporting a father with an alcohol problem. While family conflict itself may not be a risk factor, such conflict may be a factor that contributes to the quality or lack of family connection, or to a young person's level of optimism. SAVY data provide a rich source for more work in this relatively new area of thinking for Viet Nam. This is only an example of the interrelatedness of various risk and protective factors. These will be explained further in subsequent reports. However examples like this

1. The interaction between the range of various risk and protective factors has not been assessed in the results presented here. This is a very simple presentation of what is a more complex issue however emerging trends and areas for further exploration may still be drawn from application of such models.
2. Blum RW, Mann RP. Reducing the risk: Connections that make a difference in the lives of youth. Minneapolis: University of Minnesota. Department of Pediatrics. Division of General Pediatrics and Adolescent Health; 1998. Unpublished.
3. Resnick MD, Bearman PS, Blum RW, Bauman KE, Harris KM, Jones J, et al. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. JAMA. 1997;278(10):823-32.



## Chapter 12

# FINDINGS AND RECOMMENDATIONS

It is important that a number of preliminary recommendations are provided in this section, to stimulate further discussion and debate and help direct future policy and programming.

More specific recommendations will be presented in the ten SAVY policy briefs to be published in 2005. These policy briefs are based on more detailed analysis and provide in-depth recommendations about ten specific areas: HIV, gender, reproductive health, family and society, drug use and abuse, mental health, accidents/injury and physical harms, education, employment and services for youth.

## 12.1. Priority issues

SAVY results have highlighted a number of issues that need to be prioritised in future program planning and policy development. Key issues are: the provision of jobs for young people; creating more supportive school environments that keep young people there for a longer period of time. Other priority issues include the risks associated with legal drugs (alcohol and tobacco), increasing knowledge and dialogue of young people with their parents about sexuality, reproductive health and HIV/AIDS. Changing attitudes and behaviours about condoms, and reducing risky road traffic behaviours are also a priority, as are reinforcing and maintaining the positive behaviours, attitudes and supportive environments that currently protect most young people.

### Recommendations:

- Explore further avenues for job creation to increase employment of young people
- Strengthen collaboration between sectors and mass organisations including the Youth Union as a priority to upscale the delivery of programmes that provide accurate knowledge and focus on skill development, addressing

priority issues such as HIV, sexual and reproductive health, legal drug misuse, road traffic accidents...

- Design a national policy on establishing BCC networks and support services including reproductive health counselling and care for youth in the school and the community with the involvement of several sectors.
- Resources be coordinated and provided to ministries and mass organisations to speed up education programmes on reproductive health, safe sex and HIV/AIDS including mandating the inclusion of such programs into the school.
- Review and where necessary amend national policy/ legislation (and enforcement of such) in the area of alcohol and tobacco accessibility to young people

## 12.2. Target Vulnerable Young People

SAVY results suggest that targeted interventions are necessary, and/or desirable to address specific issues and also specific groups of young people.

Vulnerability and risk factors change depending on the issues, for example, pregnancy is a risk for young women but drug use affects far more young men. Clearly 'one size fits all' does not apply in this case. To be relevant to all programmes and approaches, we must acknowledge the heterogeneous nature of young people in Viet Nam.

SAVY clearly shows that ethnic minority groups require targeted programmes, resources and interventions as this group is the 'less reached' i.e. they are less able than other youth to access information and services, and in many cases, they are the poorest, the least healthy and the least educated. Separate targeted interventions are also needed for young men and young women as the mortality, morbidity and health risks differ depending on the issue.

### Recommendations:

- To designate specific resources to upscale programs and interventions targeting HIV/AIDS and reproductive health information and services for young people from ethnic minority groups.



- To design programmed interventions for strengthening knowledge and skills dimensions in the area of sexual and reproductive health education, for young women both in and out of school, including young women prior to marriage.
- To develop specific programs and interventions for young men that target a number of health compromising behaviours that are often linked including: smoking, and alcohol use, risky sexual behaviour and condom use, HIV prevention, violence, and road traffic behaviours.

### 12.3. Strengthen the Legislative and Policy Framework to Promote and Protect Young People

A supportive legal and policy framework is a necessary part of any public health approach. Policies and legislation that aim to protect young people already exists in Viet Nam although policing or adherence to these policies appears inadequate. SAVY data highlights that without support for implementation or stringent enforcement of legislative policies, education and IEC may have limited influence on young people's behaviour change and do not serve to protect young people as intended.

#### Recommendations:

- Key sectors, mass organisations and donor partners support development of new policies and legislation that protect rights of adolescents and young people and facilitate the design and implementation of integrated interventions in various sectors including social protection, education, drug use, family protection, mental health and traffic accidents
- Increased monitoring and enforcement of existing legislation in the areas of traffic accident reduction, alcohol and tobacco misuse, access to condoms and contraception, and child labour.
- Address gender issues, minority young people, unmarried youth, vulnerable groups of young people including: street youth and disabled youth in the design and implementation of adolescent and youth health and development policy and programmes.

- Greater youth participation, in appropriate contexts, in the process of community and government decisions that affect young people's lives.

### 12.4. Improve Surveillance Systems and Planning Processes to Support Adolescents and Youth

SAVY data distinguishes itself as the first national adolescent and youth baseline data. It has highlighted that in order to make significant changes in adolescent and youth health it will require cross-sector cooperation when developing future action plans and strategies.

#### Recommendations:

- The SAVY report should be disseminated to all relevant sectors, NOT only the health sector, so the main findings and how they impact on future programmed development can be considered.
- SAVY data should be used as a significant source of evidence when identifying high, medium or low priority interventions for the Master Plan for Adolescent and Youth Health. SAVY should also support future implementation and the mainstreaming of youth into existing national strategies, notably the: *The Youth Law, National Youth Strategy 2002-2010; Reproductive Health Strategy; National Nutrition Strategy; Tobacco Convention and the Injury Prevention Strategy.*
- A plan for the second and subsequent SAVY should be developed based on a five year timeline. Partners should join efforts to ensure there are sufficient resources to enable SAVY to become a regular and institutionalized surveillance measure. Partners should include the Government of Viet Nam, GSO, Youth Union, WHO, UNICEF.

### 12.5. Develop Supportive Environments

SAVY provides some evidence that risk and protective factors are relevant for youth in Viet Nam. SAVY has highlighted that young people who are



more connected to family and schools fare better than those who are not. Many interventions targeting adolescent health have focused on addressing specific risk factors and health problems rather than promoting the benefits of creating a supportive environment to prevent risk taking and promote positive behaviour. Therefore programmes to build supportive environments for young people (thereby building protective factors) should be seen as legitimate areas of investment for youth.

### Recommendations:

- The framework of risk and protective factors and supportive environments be further disseminated to policy makers and researchers (across sectors) to raise their awareness and familiarity of these approaches.
- Assess school environments for their potential to provide protective environment, and support young people to succeed and stay at school (by providing guidance and counselling when required).
- Build local community programmes that allow young people access to leisure activities and facilities including clubs that encourage a sense of connection with the community. This can help prevent inactivity, stress, risky experimentation and potential mental health problems.
- Invest in interventions that strengthen family as a protective factor to ensure young people feel connected to their parents (significant adults), receive adequate attention and care, are allowed to develop independence and provided opportunities to participate in family life.
- Explore extensions of parenting programmes that build two way dialogue between young people and their families.
- Upscale provision of youth-friendly services including counselling especially for unmarried

young people.

- Strengthen the positive peer support in mitigating risk factors for youth.

## 12.6. IEC and Mass Media

Mass media is the most popular and common medium for young people in Viet Nam to access information about sexuality, HIV and reproductive health as well as many other life issues. While urban young people increasingly have access to sophisticated mass communication tools like the internet even in remote areas the majority of young people can access television. Mass media as a communication tool and channel for social marketing and questioning social norms about condoms, contraception, gender remains largely underexplored and is clearly preferred by young people. Making messages relevant remains a challenge.

### Recommendations:

- The quality and quantity of messages targeting young people should be increased as mass media is clearly an effective tool for getting information to young people. Additional attention to quality and specificity of this information would be beneficial in terms of increasing knowledge as well as awareness.
- Social marketing campaigns targeting youth condom use need to destigmatise condoms within the framework of youth in Viet Nam attempting to create attitudes that condom use is safe, responsible, and offering protection for individuals and their partners.
- IEC programmes should be relevant to different age groups, be gender sensitive, include all geographic areas and not just focus on awareness raising but also attempt to change behaviour.



# APPENDIX

- Sample description
- Variance
  - Variance total
  - Variance urban
  - Variance rural
- Questionnaire

## SAMPLE DESCRIPTION

		Age Groups (3)			Ever been married?		Total
		14-17	18-21	22-25	Yes	No	
Urban-rural residence	City-Town	1020	919	723	255	2407	2662
	Rural	2208	1625	1089	902	4020	4922
Age Groups (3)	14-17	3228			15	3213	3228
	18-21		2544		338	2206	2544
	22-25			1812	804	1008	1812
Is member of an ethnic minority	Kinh-Chinese	2708	2160	1527	834	5561	6395
	All others	520	384	285	323	866	1189
Geographic Region	Red River Delta Region	679	626	420	183	1542	1725
	North_East Region	446	328	246	221	799	1020
	North_West Region	216	129	89	114	320	434
	North Central Region	344	201	118	95	568	663
	Coast Central Region	195	152	104	66	385	451
	Central Highland Region	265	172	121	99	459	558
	South East Region	555	510	388	156	1297	1453
	Mekong River Delta Region	528	426	326	223	1057	1280
Gender	Male	1603	1274	876	386	3367	3753
	Female	1625	1270	936	771	3060	3831
<b>Total</b>		<b>3228</b>	<b>2544</b>	<b>1812</b>	<b>1157</b>	<b>6427</b>	<b>7584</b>

## VARIANCE TOTAL

	Value	SE	95% confidence interval		Observation
Ever had job training	18.90	0.46948	17.97	19.84	7584
Ever worked for pay	54.86	1.12873	52.61	57.12	7584
Currently working for pay	34.45	1.02157	32.40	36.49	7584
Satisfied with current job	78.16	1.08586	75.99	80.34	2650
Currently looking for a(nother) job	15.58	0.31740	14.95	16.22	7584
Actively searched for job last week	42.87	2.60174	37.67	48.07	1223
Ever attended school	96.19	0.18223	95.83	96.56	7584
Among those ever in school: currently attending school	44.83	1.02447	42.78	46.88	7297
Ever received private tutoring while in school	69.10	1.90067	65.30	72.90	2841
Has been injured as a result of violence from a family member	2.22	0.03967	2.14	2.30	7584
Report no friends	12.38	0.28566	11.81	12.96	7584
Experienced death of one or both parents	9.79	0.28096	9.22	10.35	7584
Experienced divorce of parents	2.63	0.07312	2.48	2.77	7584
Living away from parents	9.74	0.31104	9.12	10.36	7584
Is a member of one or more organizations	40.07	0.89210	38.29	41.86	7584
Among those who received job training, did find the kind of job trained for	67.13	3.35344	60.42	73.84	1037
Has full Literacy (read and write)	92.82	0.42544	91.96	93.67	7584
Has internet as a source for family planning information	7.16	0.16986	6.82	7.50	7584
Has ever heard of the internet	71.55	1.75522	68.04	75.06	7584
Has ever used the internet	17.28	0.94200	15.40	19.17	7584
Has many sources of HIV information	49.28	0.93783	47.41	51.16	7584
Has all four main HIV information sources	61.55	0.96391	59.62	63.48	7584
Has mass media as HIV information source	96.46	0.29233	95.88	97.05	7584
Has family as HIV information source	88.18	0.47899	87.22	89.14	7584
Has professionals/services as HIV information source	85.26	0.75226	83.75	86.76	7584
Has mass organizations as HIV information source	68.15	0.75091	66.65	69.65	7584
Heard of HIV/AIDS	97.00	0.24663	96.50	97.49	7584
Says does not know about homosexuality	41.16	0.95194	39.26	43.07	7252
Recognizes at least 3 places to have an HIV test	63.72	0.65379	62.41	65.03	7584
Recognizes at least 6 actions to control spread of HIV	82.94	0.69251	81.55	84.32	7584
Recognizes as a means of preventing HIV: having only one sexual partner	77.91	0.30430	77.30	78.52	6882
Recognizes as a means of preventing HIV: avoiding sex with strangers	89.15	0.18924	88.77	89.53	7090
Recognizes as a means of preventing HIV: avoiding sex	76.97	0.33498	76.30	77.64	6972
Recognizes as a means of preventing HIV: avoiding buying or selling sex	92.46	0.11694	92.23	92.69	7136
Recognizes as a means of preventing HIV: avoiding sharing needles	95.66	0.07181	95.51	95.80	7224
Recognizes as a means of preventing HIV: avoiding blood transfusions	94.78	0.10131	94.58	94.98	7165

Ever had a sexually transmitted disease	0.26	0.00498	0.25	0.27	6638
outlook: Never felt sad the life	67.38	0.48185	66.42	68.35	7584
outlook: Never felt so sad or helpless you stopped	74.61	0.37974	73.85	75.37	7584
outlook: Never felt really hopeless about the future	79.96	0.32876	79.31	80.62	7584
Among those ever married: Ever hit by spouse	5.25	0.69176	3.86	6.63	1158
Among those ever married: Ever experienced any of four bad behaviors from spouse	30.83	2.24797	26.33	35.32	1158
Ever tried opium etc	0.47	0.00759	0.46	0.49	7584
Ever participated in motorcycle racing	1.21	0.01507	1.18	1.24	7584
Ever taken part in a group riot	2.49	0.04746	2.40	2.59	7584
Has had premarital sex	7.60	0.23207	7.13	8.06	7584
Among the married, had sex with someone other than spouse before marriage	6.03	0.74350	4.54	7.52	1157
Among the single, had sex	4.87	0.10442	4.66	5.08	6427
Has hurt someone enough to require medical treatment	1.35	0.02889	1.30	1.41	7584
Has carried a weapon	2.30	0.04077	2.22	2.38	7584
Has been injured as a result of violence outside the home	8.03	0.12430	7.78	8.28	7584
Has been injured as a result of violence from a family member	2.22	0.03967	2.14	2.30	7584
Number of Violence Indicators (Score)	0.14	0.00003	0.14	0.14	7584
Has tried to injure self	2.81	0.05220	2.70	2.91	7584
Have your ever smoked	22.38	0.39611	21.59	23.18	7584
Do you currently smoke more than once per week	68.95	1.79079	65.37	72.54	1741
Is there any person in your family who smokes	66.42	0.60261	65.22	67.63	7584
Have you ever finished a glass of beer or cup of liquor	48.58	0.61786	47.34	49.82	7584
Have you ever been drunk	47.75	1.02945	45.69	49.81	4841
Have you heard of drugs such as opium/marijuana/heroin/amphetamines	81.77	0.65752	80.45	83.08	7584
Do you know anyone who uses drugs such as	25.99	0.90572	24.18	27.80	7584
Have you ever heard about trafficking of women and children	81.61	0.73773	80.14	83.09	7584
Knows about any contraceptive method	97.26	0.09140	97.07	97.44	7584
Has ever used any contraceptive method	14.52	0.45625	13.61	15.43	7584
Currently is using any contraceptive method	11.13	0.35972	10.41	11.85	7584
Did you seek medical help during your most recent illness	68.15	0.63095	66.89	69.42	7584
Age at first marriage	20.01	0.00945	19.99	20.03	1155
Age at first pregnancy	20.05	0.00997	20.03	20.07	717
Age at first birth	20.42	0.01265	20.40	20.45	610
Age first smoked	16.98	0.00642	16.97	16.99	1720
Age first drank alcohol	16.77	0.00341	16.77	16.78	3770
Age first left home for one month or more	16.73	0.00965	16.71	16.75	2101
Age first worked for pay	16.45	0.00579	16.44	16.47	4099
Age at start of schooling'	6.63	0.00105	6.62	6.63	7256
Age ended schooling	15.17	0.00967	15.15	15.19	3891
Chose spouse independently	36.33	3.46739	29.39	43.26	1158
Ever away from home for one month or more	29.79	0.60837	28.58	31.01	7584



## VARIANCE URBAN

	Value	SE	95% confidence interval		Observation
Ever had job training	26.57	1.66317	23.24	29.90	2662
Ever worked for pay	51.80	2.39490	47.01	56.59	2662
Currently working for pay	35.38	2.46191	30.46	40.30	2662
Satisfied with current job	81.60	3.09587	75.40	87.79	954
Currently looking for a(nother) job	16.20	0.94890	14.30	18.10	2662
Actively searched for job last week	45.08	8.17772	28.72	61.43	465
Ever attended school	98.64	0.22751	98.18	99.09	2662
Among those ever in school: currently attending school	53.38	2.48365	48.41	58.35	2630
Ever received private tutoring while in school	78.29	4.17023	69.94	86.63	1038
Has been injured as a result of violence from a family member	3.00	0.15248	2.70	3.30	2662
Report no friends	11.34	1.34803	8.64	14.04	2662
Experienced death of one or both parents	9.84	0.84153	8.15	11.52	2662
Experienced divorce of parents	4.73	0.35411	4.02	5.44	2662
Living away from parents	5.98	0.32102	5.33	6.62	2662
Is a member of one or more organizations	40.44	4.54499	31.35	49.53	2662
Among those who received job training, did find the kind of job trained for	66.09	7.86853	50.35	81.82	469
Has full Literacy (read and write)	96.93	0.43216	96.06	97.79	2662
Has internet as a source for family planning information	16.01	0.97802	14.06	17.97	2662
Has ever heard of the internet	90.29	2.53654	85.21	95.36	2662
Has ever used the internet	45.31	6.97887	31.35	59.27	2662
Has many sources of HIV information	57.52	2.14818	53.22	61.82	2662
Has all four main HIV information sources	66.16	2.08453	61.99	70.33	2662
Has mass media as HIV information source	99.25	0.05332	99.14	99.35	2662
Has family as HIV information source	92.94	0.59092	91.76	94.12	2662
Has professionals/services as HIV information source	92.54	1.13173	90.28	94.80	2662
Has mass organizations as HIV information source	70.11	1.71510	66.68	73.54	2662
Heard of HIV/AIDS	99.51	0.04111	99.43	99.59	2662
Says does not know about homosexuality	23.44	3.13525	17.17	29.71	2618
Recognizes at least 3 places to have an HIV test	61.16	2.45552	56.25	66.08	2662
Recognizes at least 6 actions to control spread of HIV	88.59	1.18262	86.22	90.96	2662
Recognizes as a means of preventing HIV: having only one sexual partner	76.22	0.92628	74.37	78.07	2512
Recognizes as a means of preventing HIV: avoiding sex with strangers	89.17	0.43340	88.30	90.03	2591
Recognizes as a means of preventing HIV: avoiding sex	73.31	1.04654	71.21	75.40	2533
Recognizes as a means of preventing HIV: avoiding buying or selling sex	93.08	0.33159	92.42	93.74	2613
Recognizes as a means of preventing HIV: avoiding sharing needles	96.11	0.14632	95.82	96.41	2625
Recognizes as a means of preventing HIV: avoiding blood transfusions	96.04	0.19744	95.65	96.44	2618

Ever had a sexually transmitted disease	0.43	0.02296	0.38	0.47	2518
outlook: Never felt sad the life	63.75	2.04048	59.67	67.83	2662
outlook: Never felt so sad or helpless you stopped	71.53	1.84535	67.84	75.22	2662
outlook: Never felt really hopeless about the future	77.95	1.25688	75.44	80.47	2662
Among those ever married: Ever hit by spouse	6.57	2.38295	1.80	11.33	255
Among those ever married: Ever experienced any of four bad behaviors from spouse	33.72	11.37780	10.97	56.48	255
Ever tried opium etc	0.62	0.02204	0.58	0.67	2662
Ever participated in motorcycle racing	2.15	0.08458	1.98	2.31	2662
Ever taken part in a group riot	3.78	0.23897	3.30	4.26	2662
Has had premarital sex	9.03	0.62545	7.78	10.28	2662
Among the married, had sex with someone other than spouse before marriage	5.67	1.82667	2.02	9.33	255
Among the single, had sex	7.14	0.43739	6.26	8.01	2407
Has hurt someone enough to require medical treatment	1.45	0.07896	1.29	1.61	2662
Has carried a weapon	3.77	0.19746	3.37	4.16	2662
Has been injured as a result of violence outside the home	8.05	0.33092	7.39	8.72	2662
Has been injured as a result of violence from a family member	3.00	0.15248	2.70	3.30	2662
Number of Violence Indicators (Score)	0.16	0.00013	0.16	0.16	2662
Has tried to injure self	3.53	0.16761	3.20	3.87	2662
Have your ever smoked	25.07	0.98174	23.11	27.03	2662
Do you currently smoke more than once per week	68.73	4.49341	59.74	77.72	667
Is there any person in your family who smokes	64.76	2.01164	60.74	68.78	2662
Have you ever finished a glass of beer or cup of liquor	56.87	1.64046	53.59	60.15	2662
Have you ever been drunk	48.64	2.16424	44.31	52.97	1879
Have you heard of drugs such as opium/marijuana/heroin/amphetamines	91.84	0.87784	90.09	93.60	2662
Do you know anyone who uses drugs such as	42.35	4.51542	33.31	51.38	2662
Have you ever heard about trafficking of women and children	89.31	1.18405	86.95	91.68	2662
Knows about any contraceptive method	98.97	0.07954	98.81	99.13	2662
Has ever used any contraceptive method	13.10	0.83207	11.43	14.76	2662
Currently is using any contraceptive method	9.49	0.67856	8.13	10.85	2662
Did you seek medical help during your most recent illness	70.25	4.70364	60.85	79.66	2662
Age at first marriage	20.60	0.04659	20.51	20.69	253
Age at first pregnancy	20.65	0.07871	20.49	20.81	163
Age at first birth	20.99	0.07974	20.83	21.15	135
Age first smoked	16.75	0.01427	16.72	16.77	660
Age first drank alcohol	16.88	0.00849	16.86	16.89	1462
Age first left home for one month or more	16.73	0.02389	16.68	16.78	700
Age first worked for pay	17.57	0.02153	17.53	17.61	1384
Age at start of schooling'	6.35	0.00125	6.35	6.35	2617
Age ended schooling	16.30	0.04273	16.22	16.39	1176
Chose spouse independently	39.67	15.40269	8.86	70.48	255
Ever away from home for one month or more	27.30	1.46995	24.36	30.24	2662

## VARIANCE RURAL

	Value	SE	95% confidence interval		Observation
Ever had job training	16.47	0.66312	15.14	17.80	4922
Ever worked for pay	55.84	1.71111	52.41	59.26	4922
Currently working for pay	34.15	1.58035	30.99	37.31	4922
Satisfied with current job	77.03	1.60549	73.82	80.25	1696
Currently looking for a(nother) job	15.39	0.48538	14.41	16.36	4922
Actively searched for job last week	42.13	3.95057	34.23	50.03	758
Ever attended school	95.42	0.28904	94.84	96.00	4922
Among those ever in school: currently attending school	42.02	1.45370	39.11	44.93	4667
Ever received private tutoring while in school	66.01	3.05837	59.89	72.12	1803
Has been injured as a result of violence from a family member	1.97	0.05366	1.86	2.08	4922
Report no friends	12.72	0.46683	11.78	13.65	4922
Experienced death of one or both parents	9.77	0.41675	8.94	10.60	4922
Experienced divorce of parents	1.96	0.08597	1.78	2.13	4922
Living away from parents	10.93	0.49265	9.95	11.92	4922
Is a member of one or more organizations	39.96	1.51871	36.92	42.99	4922
Among those who received job training, did find the kind of job trained for	67.65	5.58871	56.47	78.82	568
Has full Literacy (read and write)	91.51	0.67289	90.16	92.86	4922
Has internet as a source for family planning information	4.35	0.16405	4.02	4.68	4922
Has ever heard of the internet	65.60	2.52420	60.56	70.65	4922
Has ever used the internet	8.39	0.45953	7.47	9.30	4922
Has many sources of HIV information	46.66	1.34868	43.97	49.36	4922
Has all four main HIV information sources	60.08	1.40199	57.28	62.89	4922
Has mass media as HIV information source	95.58	0.49172	94.60	96.56	4922
Has family as HIV information source	86.67	0.73021	85.21	88.13	4922
Has professionals/services as HIV information source	82.94	1.10528	80.73	85.16	4922
Has mass organizations as HIV information source	67.53	1.14714	65.23	69.82	4922
Heard of HIV/AIDS	96.20	0.41558	95.37	97.03	4922
Says does not know about homosexuality	47.01	1.22439	44.56	49.46	4634
Recognizes at least 3 places to have an HIV test	64.53	1.05385	62.42	66.64	4922
Recognizes at least 6 actions to control spread of HIV	81.14	1.13379	78.87	83.41	4922
Recognizes as a means of preventing HIV: having only one sexual partner	78.47	0.45304	77.57	79.38	4370
Recognizes as a means of preventing HIV: avoiding sex with strangers	89.14	0.30269	88.54	89.75	4499
Recognizes as a means of preventing HIV: avoiding sex	78.18	0.58282	77.02	79.35	4439
Recognizes as a means of preventing HIV: avoiding buying or selling sex	92.25	0.18285	91.89	92.62	4523
Recognizes as a means of preventing HIV: avoiding sharing needles	95.51	0.12202	95.26	95.75	4599
Recognizes as a means of preventing HIV: avoiding blood transfusions	94.36	0.16697	94.02	94.69	4547

Ever had a sexually transmitted disease	0.20	0.00609	0.19	0.21	4120
outlook: Never felt sad the life	68.54	0.73785	67.06	70.01	4922
outlook: Never felt so sad or helpless you stopped	75.58	0.54162	74.50	76.67	4922
outlook: Never felt really hopeless about the future	80.60	0.45764	79.69	81.52	4922
Among those ever married: Ever hit by spouse	5.00	0.89501	3.21	6.79	903
Among those ever married: Ever experienced any of four bad behaviors from spouse	30.28	2.76955	24.74	35.82	903
Ever tried opium etc	0.42	0.01103	0.40	0.45	4922
Ever participated in motorcycle racing	0.91	0.01891	0.87	0.94	4922
Ever taken part in a group riot	2.09	0.05897	1.97	2.20	4922
Has had premarital sex	7.14	0.35011	6.44	7.84	4922
Among the married, had sex with someone other than spouse before marriage	6.10	0.98559	4.12	8.07	902
Among the single, had sex	4.09	0.14544	3.80	4.38	4020
Has hurt someone enough to require medical treatment	1.32	0.04130	1.24	1.41	4922
Has carried a weapon	1.83	0.05048	1.73	1.93	4922
Has been injured as a result of violence outside the home	8.02	0.19167	7.64	8.41	4922
Has been injured as a result of violence from a family member	1.97	0.05366	1.86	2.08	4922
Number of Violence Indicators (Score)	0.13	0.00004	0.13	0.13	4922
Has tried to injure self	2.57	0.07527	2.42	2.72	4922
Have your ever smoked	21.53	0.60032	20.33	22.73	4922
Do you currently smoke more than once per week	69.04	2.78334	63.47	74.60	1074
Is there any person in your family who smokes	66.95	0.88730	65.18	68.73	4922
Have you ever finished a glass of beer or cup of liquor	45.95	0.89549	44.16	47.74	4922
Have you ever been drunk	47.41	1.68894	44.03	50.79	2962
Have you heard of drugs such as opium/marijuana/heroin/amphetamines	78.57	0.97051	76.63	80.51	4922
Do you know anyone who uses drugs such as	20.80	1.24986	18.30	23.30	4922
Have you ever heard about trafficking of women and children	79.17	1.23928	76.69	81.65	4922
Knows about any contraceptive method	96.71	0.15316	96.41	97.02	4922
Has ever used any contraceptive method	14.97	0.71081	13.55	16.39	4922
Currently is using any contraceptive method	11.65	0.54401	10.56	12.74	4922
Did you seek medical help during your most recent illness	67.49	1.24318	65.00	69.97	4922
Age at first marriage	19.90	0.01154	19.88	19.92	902
Age at first pregnancy	19.94	0.01147	19.92	19.96	554
Age at first birth	20.31	0.01493	20.28	20.34	475
Age first smoked	17.06	0.01021	17.04	17.08	1060
Age first drank alcohol	16.73	0.00587	16.72	16.74	2308
Age first left home for one month or more	16.73	0.01383	16.70	16.76	1401
Age first worked for pay	16.12	0.00691	16.11	16.14	2715
Age at start of schooling'	6.71	0.00175	6.71	6.72	4639
Age ended schooling	14.87	0.01152	14.84	14.89	2715
Chose spouse independently	35.70	4.60444	26.49	44.91	903
Ever away from home for one month or more	30.59	0.91840	28.75	32.42	4922

## GENERAL STATISTICS OFFICE - MINISTRY OF HEALTH

Personal information is  
kept confidential

Questionnaire No.

# SURVEY ASSESSMENT OF VIETNAMESE YOUTH (SAVY) QUESTIONNAIRE (SEPTEMBER 2003)

## A. IDENTIFICATION

## A1. Geographic location

Province/city (Capitalized, with tone) District/town/(Capitalized, with tone) Ward/commune (Capitalized with tone) A2. Location (Based on the list provided by GSO) ☐

- Urban area of big cities ..... 1  
(Hanoi, Ho Chi Minh City, Haiphong, Da Nang)  
Urban area of other cities ..... 2  
Town (district level) ..... 3  
Rural area ..... 4

A3. Gender ☐

- Male ..... 1  
Female ..... 2

A4. Method of data collection ☐

- Interview plus self-completed ..... 1  
Interview all two parts ..... 2

NAME OF INTERVIEWER   
NAME OF TEAM LEADER   
Date of interview (day/month/year) \_\_ / \_\_ / 2003  
Date of data checking (day/month/year) \_\_ / \_\_ / 2003  
NAME OF SUPERVISOR   
NAME OF DATA INPUT PERSON   
Date of data entry (day/month/year) \_\_ / \_\_ / 2003  
Date of data entry checking (day/month/year) \_\_ / \_\_ / 2003

## B. PERSONAL AND FAMILY BACKGROUND

B1. How old are you according to solar calendar? (Age) 

(Check: if respondent's age is more than 25 or less than 14 then finish the interview)

B2. What is your ethnicity? ☐

- Tay ..... 2  
Kinh ..... 1  
Thai ..... 3  
Muong ..... 4

H Mong ..... 5

Khmer ..... 6

Chinese ..... 7

Other (specify: \_\_\_\_\_) 8

B3. What is your religion? ☐

- None ..... 1  
Buddhism ..... 2  
Cathohism ..... 3  
Protestant ..... 4  
Caodai ..... 5  
Hoahao ..... 6  
Muslim ..... 7  
Other (specify: \_\_\_\_\_) 8

B4. Do you live with your biological father now? ☐

- Yes ..... 1 ==> Skip to B7  
No ..... 2

B5. Why don't you live with your biological father? ☐

- My father died ..... 1  
My father works/studies far from home 2 ==>Skip to B7  
My parents are divorced 3 ==>Skip to B7  
I have my own family . 4 ==>Skip to B7  
Other (specify: ..... )5 ==>Skip to B7

B6. How old were you when your father died 

(don't remember or don't know code 99)

## B7. What is your father's highest education level? (write grade completed, using conversion table)

- Did not go to school code 00, Post high school but less than bachelor code 13   
Bachelor or higher degree code 14)

## B8.1 What is your father's main occupation? If he died, what was his

occupation before he died? 

- Specify: \_\_\_\_\_  
Military ..... 1  
Leader ..... 2  
Professional, technician (mid level, senior level) 3  
Staff (basic level) ..... 4  
Private services, guard, salesman ..... 5  
Skilled farmer, timberman, fisherman ..... 6  
Trained handicraftman or similar ..... 7  
Mechanic ..... 8  
Unskilled labour ..... 9  
Unskilled agricultural jobs ..... 10  
Unemployed / Stay home ..... 11  
Don't remember/don't know ..... 99

## B8.2 What has been your father's main occupation since you were born?

- Specify: \_\_\_\_\_  
Military ..... 1



- Leader ..... 2  
 Professional, technician (mid level, senior level) ..... 3  
 Staff (basic level) ..... 4  
 Private services, guard, salesman ..... 5  
 Skilled farmer, timberman, fisherman ..... 6  
 Trained handicraftman or similar ..... 7  
 Mechanic ..... 8  
 Unskilled labour ..... 9  
 Unskilled agricultural jobs ..... 10  
 Unemployed / Stay home ..... 11  
 Don't remember/don't know ..... 99
- B9. Do you live with your biological mother now? ..... ☐  
 Yes ..... 1 ==>Skip to B12  
 No ..... 2
- B10. Why don't you live with your biological mother? ..... ☐  
 My mother died ..... 1  
 My mother works/studies far from home 2 ==>Skip to B12  
 My parents are divorced ..... 3 ==>Skip to B12  
 I have my own family ..... 4 ==>Skip to B12  
 Other (specify: ..... ) 5 ==>Skip to B12
- B11. How old were you when your mother died ..... ☐  
 (don't remember, don't know code 99)
- B12. What is your mother's highest education level? (write grade completed, using conversion table  
 Did not go to school code 00, Post high school but less than bachelor code 13 ..... ☐  
 Bachelor or higher degree code 14)
- B13.1 What is your mother's main occupation? If she died, what was her occupation before she died? ..... ☐  
 Specify:.....)  
 Military ..... 1  
 Leader ..... 2  
 Professional, technician (mid-level, senior level) 3  
 Staff (basic level) ..... 4  
 Private service, guard, salesman ..... 5  
 Skilled farmer, timberman, fisherman ..... 6  
 Trained handicraftman or similar ..... 7  
 Mechanic ..... 8  
 Unskilled labour ..... 9  
 Unskilled agricultural jobs ..... 10  
 Do nothing / Stay home ..... 11  
 Don't remember/don't know ..... 99
- B13.2 What has been your mother's main occupation since you were born?  
 Specify:.....)  
 Military ..... 1  
 Leader ..... 2  
 Professional, technician (mid level, senior level) 3  
 Staff (basic level) ..... 4  
 Private services, guard, salesman ..... 5  
 Skilled farmer, timberman, fisherman ..... 6  
 Trained handicraftman or similar ..... 7  
 Mechanic ..... 8  
 Unskilled labour ..... 9  
 Unskilled agricultural jobs ..... 10  
 Unemployed / Stay home ..... 11  
 Don't remember/don't know ..... 99
- B14.1 How many biological brothers do you have? ..... ☐  
 (including those who died, not yourself)
- 14.2 How many biological sisters do you have? ..... ☐  
 (including those who died, not yourself)
- 14.3. How many biological brothers live with you now, not including

- yourself? ..... ☐  
 14.4. How many biological sisters live with you now, not including yourself ? ..... ☐  
 B15. What is your birth order? ..... ☐  
 The only child ..... 1  
 The first ..... 2  
 The last ..... 3  
 In the middle ..... 4
- B16. What place were you born? ..... ☐  
 Urban area of big cities (Hanoi, Ho Chi Minh City, Hai phong, Danang) ..... 1  
 Urban area of other cities ..... 2  
 Town (district level) ..... 3  
 Rural area ..... 4  
 Don't know ..... 5
- B17. Where did you mostly live when you were 8 - 14 years old? .. ☐  
 City ..... 1  
 Town ..... 2  
 Rural area ..... 3  
 Abroad ..... 4  
 Don't know ..... 9
- B18. Have you ever lived away from home continuously for more than one month? ..... ☐  
 Yes ..... 1  
 No ..... 2 ==>Skip to B21
- B19. How old were you when you first lived away from home for more than one month? ..... ☐  
 (don't remember code 99)
- B20. What was the main reason that made you live away from home (the first time)? ..... ☐  
 To study ..... 1  
 To earn a living ..... 2  
 To take a holiday, vacation ..... 3  
 To join the army ..... 4  
 Other (specify: ..... )5
- B21. How many people are there in your family ? (number of people) ☐  
 B22. Do you have your own room? (nobody shares your room) .... ☐  
 Yes ..... 1  
 No ..... 2
- B23. Does your family own [...]?  
 Yes ..... 1  
 No ..... 2
- B23.1. Electric fan ..... ☐  
 B23.2. TV ..... ☐  
 B23.3. Radio ..... ☐  
 B23.4. Video cassette, VCD, DVD player ..... ☐  
 B23.5. Bicycle ..... ☐  
 B23.6. Motobike ..... ☐  
 B23.7. Boat ..... ☐  
 B23.8. Refrigerator ..... ☐  
 B23.9. Computer ..... ☐  
 B23.10. Telephone ..... ☐  
 B23.11. Cell phone ..... ☐
- B24. What source of power (energy) does your family use for lighting? ..... ☐  
 National power line ..... 1  
 Small fueled/hydrolic generator ..... 2  
 Battery ..... 3

Kerosene lamp ..... 4  
Other: (specify: \_\_\_\_\_) 5

B25. What is the main source of drinking water used in your family? ☐ ☐  
Private tap water ..... 1  
Public tap water ..... 2  
Water bought from other place including bottled water ..... 3  
Pumped water from drilled well ..... 4  
Well water ..... 5  
Filtered spring water ..... 6  
Unfiltered spring water ..... 7  
Shallow well water ..... 8  
Rain water ..... 9  
River, lake, pond water ..... 10  
Other (Specify: \_\_\_\_\_) 11

B26. Do you know how to read and write? ☐  
Know how to read but not write ..... 1  
Know how to write but not read ..... 2  
Know how to read and write ..... 3  
Don't know how to read or write ..... 4  
5

B27. Have you ever gone to school? ☐  
Yes ..... 1 ==>Skip to B29  
No ..... 2

B28. What was the main reason why you never went to school? ☐  
Can't afford school fees ..... 1  
Too ill/disabled ..... 2  
Have to work for my family ..... 3  
School was too far from home ..... 4  
My family doesn't want me to go to school ..... 5  
Study doesn't do any good ..... 6  
Don't want to go to school ..... 7  
Don't know Kinh language ..... 8  
Other (specify: \_\_\_\_\_) 9

## MOVE TO QUESTION B40

B29. How old were you when you started going to school?  
(don't remember code 99) ☐ ☐

B30. Do you currently go to school, college, university? ☐  
Yes ..... 1 ==>Skip to B34  
No ..... 2

B31. How old were you when you stopped going to school? ☐  
(don't remember code 99)

B12. What grade did you complete before you stopped going to school? (write grade completed, using conversion table  
Did not go to school code 00, Post high school but less than bachelor code 13 .....  
Bachelor or higher degree code 14)

B33. What was the main reason that made you stop going to school? ☐ ☐  
Couldn't afford school fees ..... 1  
Too ill/disabled ..... 2  
Have to work for my family ..... 3  
School was too far from home ..... 4  
My family didn't want me to go to school ..... 5  
Didn't want to go to school any more ..... 6  
Didn't pass the exams ..... 7  
Was pregnant ..... 8  
Married ..... 9  
My friends dropped out of school ..... 10  
I did not speak Kinh very well ..... 11

My study ability was weak ..... 12  
I was usually teased in school ..... 13  
I was punished, disciplined by teacher ..... 14  
Unsatisfactory teaching quality ..... 15  
Further study no use to me ..... 16  
Classroom was too small ..... 17  
There is no space for me in school ..... 18  
I graduated ..... 19  
Other (Specify: \_\_\_\_\_) 20  
Don't know ..... 99

## MOVE TO QUESTION B40

B34. What grade are you in now? (write grade completed, using conversion table  
Did not go to school code 00, Post high school but less than bachelor code 13 ..... ☐ ☐  
Bachelor or higher degree code 14)

B35. The followings are statements about your school, you may agree, disagree or don't know how to answer (not sure).  
Agree ..... 1  
Disagree ..... 2  
Not sure ..... 3  
B33.1. I tried hard to study ..... ☐  
B33.2. Teachers treat every student equally ..... ☐  
B33.3. Sometimes you do not want to go to school ..... ☐  
B33.4. Teachers praise me when I perform well in class ..... ☐  
B33.5. I really want to enter university ..... ☐  
B33.6. Disabled students are given access to my school ..... ☐  
B33.7. Study workload is too heavy ..... ☐  
B33.8. Students have opportunity to give comments about school ☐

B36. Did you go to primary/secondary/high school from January 2003? ☐  
(including night school or any government providing schooling)  
Yes ..... 1  
No ..... 2 ==> Skip to B40

B37. Where did you live while you were attending school? ☐  
At home ..... 1  
In school dormitory ..... 2  
With other family ..... 3  
Other (Specify: ..... )4

B38. When in school, did you receive private tutoring? ☐  
Yes ..... 1  
No ..... 2

B39. Have you ever been disciplined enough that it was recorded? ☐  
Yes ..... 1  
No ..... 2

B40. Have you ever received any training for a certain job? ☐  
Yes I have finished ..... 1  
Yes I am taking one ..... 2 ==>Skip to B42  
No I haven't ..... 3 ==>Skip to B42

B41. Did you find a job that you'd been trained for? ☐  
Yes ..... 1  
No ..... 2

B42. Have you ever worked to earn money? ☐  
Yes ..... 1  
No ..... 2 ==>Skip to B48

B43. At what age did you first work for money? ☐ ☐  
(Don't remember code 99)

B44. Do you currently have a paid job? ☐  
 Yes ..... 1  
 No ..... 2 ==>Skip to B48

B45. What is your main occupation now? ☐  
 Specify.....  
 Military ..... 1  
 Leader ..... 2  
 Professional, technician (mid-level, senior level) ..... 3  
 Staff (basic level) ..... 03 4  
 Private service, guard, salesman ..... 5  
 Skilled farmer, forester, fisherman ..... 6  
 Trained handicraftman or similar ..... 7  
 Mechanic ..... 8  
 Unskilled labour ..... 9  
 Unskilled agricultural jobs ..... 10  
 Unemployed / Stay home ..... 11==>Skip to B48

B46. Whom are you working for? ☐  
 Government institution, military ..... 1  
 State-run enterprises ..... 2  
 Communist Party institution, mass organization, association ..... 3  
 Co-operative enterprise ..... 4  
 Private enterprise ..... 5  
 Small, family enterprise ..... 6  
 Foreign-owned enterprise ..... 7  
 Joint-venture with government/co-op/private ..... 8  
 Other joint-venture ..... 9  
 Other (Specify.....) 10  
 Self-employed ..... 11

B47. Are you satisfied with your current job? ☐  
 Yes ..... 1  
 No ..... 2

B48. Are you currently looking for a job? ☐  
 Yes ..... 1  
 No ..... 2 ==>Skip to B50

B49. Did you do anything last week in order to find a job? ☐  
 Yes ..... 1  
 No ..... 2

B50. According to you, is it easy or difficult to find a job nowadays? ☐  
 Very difficult ..... 1  
 Relatively difficult ..... 2  
 Depending on which job ..... 3  
 Relatively easy ..... 4  
 Very easy ..... 5  
 Don't know ..... 9

B51. Do you think your economic condition in the next three year (by the end of 2006)  
 will be better, about the same or worse than it is now ? ☐  
 Better ..... 1  
 About the same ..... 2

### C. PUBERTY AND SEXUAL KNOWLEDGE AND BEHAVIOR

Puberty is the term which refers to the period of physical transformation from childhood to adulthood

C1. **If you are a male:** how old were you when you had your first wetdream (age)

**If you are a female:** how old were you when you had your first

period? (age)

(if don't remember write 99, if never had wetdream/period write 97, then move to C4) ☐

C2. Did you talk to anyone about it at the time? ☐  
 Yes ..... 1  
 No ..... 2 ==> Skip to C4

C3. Whom did you first talk to? ☐  
 Parents ..... 1  
 Brother/sister ..... 2  
 Relatives ..... 3  
 Neighbors ..... 4  
 Teachers ..... 5  
 Friends ..... 6  
 Boyfriend/girlfriend ..... 7  
 Others (specify:.....) 8  
 Don't remember ..... 9

C4. Have you ever heard about the following topics? ☐  
 Yes ..... 1  
 No ..... 2  
 C4.1.Family planning ..... ☐  
 C4.2.Pregnancy/Menstruation ..... ☐  
 C4.3.Gender and sexual relationship ..... ☐  
 C4.4.Love, marriage.. ..... ☐  
 Check, if All C4s have "No" answers, ==> move to question D1

C5. Did you hear about this/these topics from the following sources? ☐  
 Yes ..... 1  
 No ..... 2  
 C5.01.TV ..... ☐  
 C5.02.Radio ..... ☐  
 C5.03.Newspaper/Magazine ..... ☐  
 C5.04.Books ..... ☐  
 C5.05.Father ..... ☐  
 C5.06.Mother ..... ☐  
 C5.07.Sisters ..... ☐  
 C5.08.Brothers ..... ☐  
 C5.09.Relatives ..... ☐  
 C5.10.Teachers ..... ☐  
 C5.11.Health professionals ..... ☐  
 C5.12.Friends ..... ☐  
 C5.13.Boyfriend/girlfriend ..... ☐  
 C5.14.Internet ..... ☐  
 C5.15. P&FP Volunteers(Population and Family planning) ..... ☐  
 C5.16.Other (specify.....) ☐

C6. In your neighborhood, according to you, how many young unmarried males have experienced sexual relationship? ☐  
 (don't know then code 9)  
 No one ..... 1  
 Very few ..... 2  
 Some ..... 3  
 Many ..... 4  
 Almost all ..... 5  
 Don't know ..... 9

C7. In your neighborhood, according to you, how many young unmarried females have experienced sexual relationship? ☐  
 (don't know then code 9)  
 No one ..... 1  
 Very few ..... 2

Some ..... 3  
 Many ..... 4  
 Almost all ..... 5  
 Don't know ..... 9

C8. Do you know what homosexuality is? ☐  
 Yes ..... 1  
 No ..... 2 ==>Skip to D1

C9. Would you accept a friend who is homosexual? ☐  
 Yes ..... 1  
 No ..... 2  
 Don't know ..... 9

C10. Do you have any friends who are homosexual / bisexual ☐  
 Yes ..... 1  
 No ..... 2  
 Don't know ..... 9

## D.DATING AND FRIENDSHIP

D1. Have you ever been married? ☐  
 Yes ..... 1  
 No ..... 2

## E. REPRODUCTIVE HEALTH AND HIV/AIDS

E1. Have you heard about HIV/AIDS ☐  
 Yes ..... 1  
 No ..... 2 ==>Question E9

E2. Have you heard about HIV/AIDS from the following sources?  
 Yes ..... 1  
 No ..... 2

E2.01. Radio, TV, newspapers and magazines ☐  
 E2.02. Posters, loud speakers, meetings ☐  
 E2.03. Your spouse ☐  
 E2.04. Leaflets, booklets, brochures ☐  
 E2.05. Health facilities, health professionals ☐  
 E2.06. At school, teachers ☐  
 E2.07. Friends ☐  
 E2.08. Organizations: Women's Union, Youth Union P&FP volunteers ☐  
 E2.09. Other members of your family ☐  
 E2.10. Other (specify \_\_\_\_\_) ☐

E3. Is it possible for a person who looks healthy to have HIV? ☐  
 Yes ..... 1  
 No ..... 2  
 Don't know ..... 9

E4. Where can a person go in order to have his/her HIV test?  
 Yes ..... 1  
 No ..... 2  
 Don't know ..... 9

E4.01. Hospital ☐  
 E4.02. Health center ☐  
 E4.03. Public clinic ☐  
 E4.04. Traditional clinic ☐

E4.05. Private clinic ☐  
 E4.06. Other (specify \_\_\_\_\_) ☐

E5. According to you, can the following prevent HIV?  
 Yes ..... 1  
 No ..... 2  
 Don't know ..... 9

E5.01. Using condom when having sexual intercourse ☐  
 E5.02. Have only one sexual partner ☐  
 E5.03. Avoid having sex with strangers ☐  
 E5.04. Avoid having sex ☐  
 E5.05. Avoid buying or selling sex ☐  
 E5.06. Avoid sharing needles ☐  
 E5.07. Avoid blood transfusion ☐  
 E5.08. Other (specify \_\_\_\_\_) ☐

E6. According to you, what should a person with HIV/AIDS do for the sake of his/herself and others?  
 Yes ..... 1  
 No ..... 2  
 Don't know ..... 9

E6.01. Use condom when having sexual intercourse ☐  
 E6.02. Avoid sharing toothbrushes, razors ☐  
 E6.03. Avoid sharing needles ☐  
 E6.04. Encourage sexual partner to have HIV test ☐  
 E6.05. Take care of his/her health with good nutritional diet, and seek doctor's advice if being ill ☐  
 E6.06. Seek help from psychologist ☐  
 E6.07. Do not breast feed their baby ☐

E7. If a man in your community has HIV/AIDS what should you do?  
 E7.01. Help him ☐  
 Yes ..... 1  
 No ..... 2  
 Don't know ..... 9

E7.02. Keep normal contact but be aware to protect yourself ☐  
 Yes ..... 1 ==> Question E7.04  
 No ..... 2  
 Don't know ..... 9

E7.03. Keep a distance from him ☐  
 Yes ..... 1  
 No ..... 2  
 Don't know ..... 9

E7.04. Other (specify and code 1, no then code 2 \_\_\_\_\_) ☐  
 E8. If a woman in your community has HIV/AIDS what should you do?

E8.01. Help her ☐  
 Yes ..... 1  
 No ..... 2  
 Don't know ..... 9

E8.02. Keep normal contact but be aware to protect yourself ☐  
 Yes ..... 1 ==> Question E8.04  
 No ..... 2  
 Don't know ..... 9

E8.03. Keep a distance from her ☐  
 Yes ..... 1  
 No ..... 2  
 Don't know ..... 9

E8.04. Other (specify and code 1, no then code 2 \_\_\_\_\_) ☐

E9. Besides HIV/AIDS, there are some other diseases that are sexually transmitted.

Have you ever heard of the following diseases?  
 Yes ..... 1  
 No ..... 2

- E9.01. Syphilis ..... ☐  
 E9.02. Gonorrhea ..... ☐  
 E9.03. Chlamydia ..... ☐  
 E9.04. Genital warts ..... ☐  
 E9.05. Chancroid ..... ☐  
 E9.06. Granuloma ..... ☐  
 E9.07. Herpes ..... ☐  
 E9.08. Trichomonas ..... ☐  
 E9.9. Hepatitis B ..... ☐  
 E9.10. Other (specify ..... ) ☐

**IF THEY ARE ALL NO ANSWERS (CODE 2) THEN  
MOVE TO QUESTION E12**

- E10. Have you ever had any of the above diseases? ..... ☐  
 Yes ..... 1  
 No ..... 2 ==> Question E12  
 E11. What did you do the most recent time you had the disease?  
 Yes ..... 1  
 No ..... 2  
 E11.1. Did nothing, waited for the disease to go ..... ☐  
 E11.2. Treated myself (including buying medicine) ..... ☐  
 E11.3. Went to public health facilities ..... ☐  
 E11.4. Went to private clinic ..... ☐  
 E11.5. Other ..... ) ☐

**CONTRACEPTIVE USE**

- E12. According to you, when is a woman most likely to get pregnant from  
sexual intercourse? ..... ☐  
 Seven Days before her period ..... 1  
 During her period ..... 2  
 7 days after her period. .... 3  
 2 weeks before of after her period ..... 4  
 Equally likely anytime during the period ..... 5  
 Don't know ..... 9

E13 Contraceptive methods (Answer from left to right)	E13.a Do you know about [...] ? Yes.....1 No..... 2 => next method	E13.b Have you ever used [...] before? Yes.....1 No..... 2	E13.c Do you currently use [...] ? Yes.....1 No..... 2
E13.1. IUD			
E13.2. Contraceptive pill			
E13.3. Condom			
E13.4. Injectable contraception			
E13.5. Morning after pill (Postinor)			
E13.6. Female sterilization			
E13.7. Vasectomy			
E13.8. Withdrawal			
E13.9. Ogino knauss			
E13.10. Spermicide			
E13.11. Other (specify ..... )			

- E14. Followings are statements about condom, you may answer agree,  
disagree or don't know how to answer  
 Agree ..... 1  
 Disagree ..... 2  
 Don't know ..... 9

- E14.1. Condoms decreases sexual desire ..... ☐  
 E14.2. It's expensive to use condoms regularly ..... ☐  
 E14.3. Condoms can prevent pregnancy if used properly ..... ☐  
 E14.4. Condoms can prevent STDs if used properly ..... ☐  
 E14.5. Condoms can prevent HIV/AIDS if used properly ..... ☐  
 E14.6. If a woman carries a condom, she may have improper  
relationships ..... ☐  
 E14.7. If a man carries a condom, he may have improper relationships ☐  
 E14.8. Condoms are only for prostitutes and unfaithful people ... ☐

**UNMARRIED RESPONDENT, MOVE TO G1**

**F. FOR MARRIED RESPONDENT**

- F1. How old were you when you first married? ..... ☐  
 (Don't know then code 99)  
 F2. How old was your spouse at that time ..... ☐  
 (don't know then code 99)  
 F3. Who decided who would be your wife, husband? ..... ☐  
 Myself ..... 1  
 My family, without my decision ..... 2  
 Myself and my family ..... 3  
 Other (specify ..... ) 4  
 F4. Are you satisfied with your married life? ..... ☐  
 Very satisfied ..... 1  
 Satisfied ..... 2  
 So so ..... 3  
 Unsatisfied ..... 4  
 Very unsatisfied ..... 5  
 F5. Has your spouse done any of the following things to you?  
 Yes ..... 1  
 No ..... 2  
 F11.1. Yelling, using foul language ..... ☐  
 F11.2. Prohibiting you from doing certain things ..... ☐  
 F11.3. Hit you ..... ☐  
 F11.4. Other bad behaviors (specify: ..... ) ☐  
 F6. Right after marriage, whom did you and your spouse live with? ☐  
 Lived with the husband's family ..... 1  
 Lived with the wife's family ..... 2  
 Lived by yourselves ..... 3  
 Other (specify ..... ) 4

**G. HEALTH**

- G1. Have you been sick or had any symptoms of illness during the last  
month? ..... ☐  
 Yes ..... 1



- No ..... 2 ==> Skip to G3
- G2. What symptom(s) did you have?
- Yes ..... 1
- No ..... 2
- G2.1. Common cold ..... ☐
- G2.2. Diarrhea ..... ☐
- G2.3. Trouble breathing ..... ☐
- G2.4. Fever, headache ..... ☐
- G2.5. Stomach ache ..... ☐
- G2.6. Other (specify \_\_\_\_\_) ☐
- G3. Do you have any of the following diseases/disability?
- Yes ..... 1
- No ..... 2
- G3.1. Asthma ..... ☐
- G3.2. Other respiratory diseases ..... ☐
- G3.3. Digestive diseases ..... ☐
- G3.4. Cardio-vascular diseases ..... ☐
- G3.5. Congenital abnormalities ..... ☐
- G3.6. Vision problems ..... ☐
- G3.7. Goiter (Iodine deficiency) ..... ☐
- G3.8. Tuberculosis ..... ☐
- G3.9. Cancer, tumour ..... ☐
- G3.10. Polio ..... ☐
- G3.11. Back bone curve (due to improper sitting) ..... ☐
- G3.12. Other (specify \_\_\_\_\_) ☐
- G4. Have you ever been too sick to go to school / to work during the last 12 months?
- Yes ..... 1
- No ..... 2
- G5. Have you had any accident or injury during the last 12 months that required medical treatment?
- Yes ..... 1
- No ..... 2 ==> Skip to G7
- G6. Where did you have that accident / injury?
- Yes ..... 1
- No ..... 2
- G6.1. On the road / street ..... ☐
- G6.2. At school ..... ☐
- G6.3. At work ..... ☐
- G6.4. At home ..... ☐
- G6.5. In a public place (train, bus station, market) ..... ☐
- G6.6. Other \_\_\_\_\_ ☐
- G7. Did you seek medical help during the most recent illness/accident?
- Yes ..... 1
- No ..... 2 ==> Skip to G9
- G8. Where did you seek help?
- Yes ..... 1
- No ..... 2
- G8.1. School health ..... ☐
- G8.2. Bought medicine for self treatment ..... ☐
- G8.3. Private clinic ..... ☐
- G8.4. Traditional healer ..... ☐
- G8.5. Commune health center ..... ☐

- G8.6. District health center ..... ☐
- G8.7. Provincial/central hospital ..... ☐
- G8.8. Other ..... ☐

**IF FEMALE, MOVE TO G10. IF MALE, MOVE TO H1**

- G9. Why didn't you seek medical help? ..... ☐
- It was not serious ..... 1
- I had to go too far ..... 2
- It was inconvenient ..... 3
- Did not have enough money ..... 4
- Too shy ..... 5
- Did not trust the quality of health service ..... 6
- The service was not friendly ..... 7
- Other (specify \_\_\_\_\_) 8

**FEMALE RESPONDENT ONLY**

**Check, male respondent skip question G10 to G23, move to H1**

**WOMEN AND CHILD HEALTH**

- G10. Have you ever been pregnant? ..... ☐
- Yes ..... 1
- No ..... 2 ==> Skip to H1
- G11. How old were you when you first got pregnant?
- 
- (Don't know then code 99)
- G12. Did you have your pregnancy check-up during your first pregnancy? .
- Yes ..... 1
- No ..... 2 ==> Skip to G14
- G13. Where did you go for any check-up during your first pregnancy? . . .
- Commune health center ..... 1
- District health center/ hospital ..... 2
- Private clinic ..... 3
- Other health facility ..... 4
- Other (Specify \_\_\_\_\_) 5
- Don't know, don't remember ..... 9
- G14. Have you ever heard about anemia among pregnant women because of iron deficiency ? ..... ☐
- Yes ..... 1
- No ..... 2
- G15. Did you take iron pills during your most recent pregnancy? ... ☐
- Yes ..... 1
- No ..... 2
- Took some pills but don't know what they were 9
- G16. Have you ever given birth? ..... ☐
- Yes ..... 1
- No ..... 2 ==> Skip to H1
- G17. How old were you when you first gave birth .....
- (Don't remember then code 99)
- G18. Where did you give birth to your most recent child? ..... ☐
- At a health facility ..... 1
- At home ..... 2
- At other place (Specify: \_\_\_\_\_) 3
- G19. How many children have you given birth to .....
- (not including those who died at birth)? .....
- G20. Who attended your most recent delivery?
- Health professional ..... 1
- Family member ..... 2

Traditional birth attendant ..... 3  
 Friends ..... 4  
 Other person (specify: \_\_\_\_\_) 5  
 Nobody ..... 6

G21. In your most recent pregnancy and delivery did you have tetanus shots as instructed ..... ☐  
 Yes ..... 1  
 No ..... 2

G22. Did you have any complications in your most recent pregnancy? ☐  
 Yes ..... 1  
 No ..... 2

G23. How many times did you have a pregnancy check-up during your most recent pregnancy? (Don't remember then code 99) ..

## H. HABITS AND BEHAVIORS

H1. Have you ever smoked? ..... ☐  
 Yes ..... 1  
 No ..... 2 ==>Skip to H6

H2. How old were you when you first smoked? ..... ☐  
 (Don't remember then code 99)

H3. What was the main reason for you to start smoking? ..... ☐  
 All my friend smoke ..... 1  
 To show my adulthood ..... 2  
 Too tense ..... 3  
 People around me smoke ..... 4  
 Smoking is stylish ..... 5  
 To show my manhood ..... 6  
 Other reason (specify \_\_\_\_\_) 7

H4. Do you currently smoke more than once per week? ..... ☐  
 Yes ..... 1  
 No ..... 2 ==>Skip to H6

H5. Have you ever tried to give up smoking? ..... ☐  
 Yes ..... 1  
 No ..... 2

H6. Does anyone in your family smoke?  
 Yes ..... 1  
 No ..... 2

H6.1. Mother ..... ☐  
 H6.2. Father ..... ☐  
 H6.3. Sisters ..... ☐  
 H6.4. Brother ..... ☐  
 H6.5 Spouse ..... ☐  
 H6.6. Other (Specify \_\_\_\_\_) ☐

H7. Do you have any close friends who smoke? ..... ☐  
 Yes ..... 1  
 No ..... 2

H8. Have you ever finished a glass of beer or a cup of liquor? .... ☐  
 Yes ..... 1  
 No ..... 2 ==>Skip to H10  
 Never ..... 3 ==>Skip to H12

H9. How old were you when you first finished a glass of beer or a cup of liquor (Don't remember then code 99) .....

H10. Have you ever been drunk? ..... ☐

Yes ..... 1  
 No ..... 2 ==>Skip to H12

H11. How many times were you drunk during the last month? .... ☐  
 Once ..... 1  
 2-3 times ..... 2  
 More than 3 times ..... 3  
 None ..... 4

H12. Does anyone in your family drink alcohol daily or have an addiction to alcohol?  
 Yes ..... 1  
 No ..... 2

H12.1. Mother ..... ☐

H12.2. Father ..... ☐

H12.3. Sisters ..... ☐

H12.4. Brothers ..... ☐

H12.5 Spouse ..... ☐

H12.6. Other (Specify \_\_\_\_\_) ☐

H13. Have you heard about any drugs such as opium, marijuana, heroin or amphetamines? ..... ☐  
 Yes ..... 1  
 No ..... 2

H14. Do you know anyone who uses drug such as opium, marijuana, heroin, or amphetamines ..... ☐  
 Yes ..... 1  
 No ..... 2

H15. Have you ever ridden a motobike? ..... ☐  
 Yes ..... 1  
 No ..... 2

H16. Do you usually wear a helmet when driving or as a passenger on a motobike? ..... ☐  
 Yes ..... 1  
 No ..... 2

H17. Give the main reason that may make you wear a helmet regularly?  
 Legal obligation ..... 1  
 Requirement from school ..... 2  
 See, hear about accidents, mortality due to traffic accidents ..... 3  
 Media campaign ..... 4  
 Free helmet ..... 5  
 Easy-to-wear helmet ..... 6  
 Other reason ..... 7  
 No reason (specify \_\_\_\_\_) 8

H18. Have you ever had a traffic accident? ..... ☐  
 Yes ..... 1  
 No ..... 2

H19. Have you ever heard about trafficking of women and children? ☐  
 Yes ..... 1  
 No ..... 2 ==>Skip to I1

H20. Do you know anyone who was trafficked? ..... ☐  
 Yes ..... 1  
 No ..... 2

## I. SOCIAL FACTORS

### FAMILY

I1. The following statements are about you and your family situation when

you were 12 to 18.

You may agree, disagree or not know how to answer,

Agree ..... 1

Partly agree ..... 2

Disagree ..... 3

Don't know ..... 9

When you were 12-18 you observed [.....]

I1.1. Family members helped one another in difficult times ..... ☐

I1.2. When having difficulties I felt more comfortable sharing with non-family members ..... ☐

I1.3. In my family, everyone went his/her own way ..... ☐

I1.4. Family members knew other members' close friends ..... ☐

I1.5. Family members treated one another equally ..... ☐

I1.6. Family members shared responsibility ..... ☐

I1.7. In my family, I usually was asked for my opinions and they were taken seriously ..... ☐

I1.8. There were frequent quarrels and conflicts in my family ..... ☐

## FRIENDS

I2. Do you have a group of friends with whom you often keep company? ☐

Yes ..... 1

No ..... 2==>Skip to I5

I3. Does the group contain both boys and girls? ..... ☐

Yes ..... 1

No ..... 2

I4. Does group contain mostly boys, mostly girls or half and half? ..... ☐

All or mostly boys ..... 1

All or mostly girls ..... 2

Half boys half girls ..... 3

I5. Is there any pressure from your friends for you to do the following [.....] ?

A little pressure ..... 1

Some pressure ..... 2

No pressure ..... 3

I5.1. Smoking ..... ☐

I5.2. Drinking ..... ☐

I5.3. Using amphetamines ..... ☐

I5.4. Watching pornography ..... ☐

I5.5. Having premarital sex ..... ☐

I5.6. Trying drugs ..... ☐

I5.7. Causing Trouble ..... ☐

I6. Do your friends encourage you to avoid [.....] ? Encourage ..... 1  
Do not encourage. ... 2

I6.1. Smoking ..... ☐

I6.2. Drinking ..... ☐

I6.3. Using amphetamines ..... ☐

I6.4. Watching pornography ..... ☐

I6.5. Having premarital sex ..... ☐

I6.6. Trying drugs ..... ☐

I6.7. Causing trouble ..... ☐

I7. Are you a member of any mass organization or clubs in your community? ..... ☐

Yes ..... 1

No ..... 2

I8. How easy or difficult is it to find [.....] in your community?

Easy ..... 1

Difficult ..... 2

Very difficult ..... 3

Impossible ..... 4

Don't know ..... 9

I8.1. Cigarettes ..... ☐

I8.2. Alcohol ..... ☐

I8.3. Drugs, and amphetamines ..... ☐

I8.4. Pornography ..... ☐

I8.5. Stolen goods ..... ☐

I9. How much do you agree with the following statements about yourself?

Completely agree ..... 1

Partly agree ..... 2

Disagree ..... 3

Don't know ..... 9

I9.1. I have some good qualities ..... ☐

I9.2. I am not proud of myself ..... ☐

I9.3. I believe that I can do what others do ..... ☐

I9.4. Sometimes I feel I am no good at all ..... ☐

I9.5. I think I am valuable to my family ..... ☐

I10. Do you completely agree / partly agree or disagree with the following statements?

Completely agree ..... 1

Partly agree ..... 2

Disagree ..... 3

Don't know ..... 9

I10.1. I will have a happy family in the future ..... ☐

I10.2. I will have a job that I like ..... ☐

I10.3. I will have opportunity to do what I want ..... ☐

I10.4. I will have a good income to live comfortably ..... ☐

## J. MEDIA

J1. How often did you watch TV during the last month? ..... ☐

Never ..... 1

Everyday ..... 2

Nearly everyday ..... 3

More than once a week ..... 4

Less than once a week ..... 5

J2. List 2 TV program that you like the best:

(don't have preference then note on the first line):

First program ..... ☐

Second program ..... ☐

News ..... 1

Movies ..... 2

Music ..... 3

Sports ..... 4

Quiz Shows ..... 5

Animal Documentary ..... 6

Childrens Shows ..... 7

Drama/play ..... 8

Other (specify ..... ) 9

Don't know ..... 99

J3. How often did you listen to the radio during the last month? ..... ☐

Never ..... 1

Every Day ..... 2

Nearly every day ..... 3

More than once a week ..... 4

Less than once a week ..... 5

- J4. List 2 radio programs that you like the best  
(don't have preference then note on the first line1):

First program .....

Second program .....

- News ..... 1  
Military program ..... 2  
Music program ..... 3  
Sports ..... 4  
Story Telling ..... 5  
Rural Programme .....  
Childrens Shows ..... 6  
Drama/play ..... 8  
Other (specify ..... ) 9  
Don't know ..... 99

- J5. How often did you read the newspapers or magazines during the last month? .....

- Never ..... 1  
Every day ..... 2  
Nearly every day ..... 3  
More than once a week ..... 4  
Less than once a week ..... 5

- J6. List 2 names of newspapers/magazines that you like the most  
(don't have preference then note on the first line1):

First newspaper .....

Second newspaper .....

- The People ..... 1  
The Labor ..... 2  
The Vietnamese Woman ..... 3  
The People Military ..... 4  
The People Police ..... 5  
The Sport ..... 6  
The Law ..... 7  
The Pioneer ..... 8  
The Youth ..... 9  
The Young ..... 9  
The Science and life ..... 10  
The World Security ..... 11  
The Youth Pioneer ..... 12  
Children's Newspaper ..... 14  
Literature Newspaper ..... 15  
The Collaborative ..... 16  
The Communist Magazine ..... 17  
The Knowledge ..... 18  
Young Fashion ..... 19  
The News ..... 20  
Students Flower ..... 21  
Family and Society ..... 22  
Health and Life ..... 23  
Buying and Selling ..... 24  
Other (specify ..... ) 25  
Don't know ..... 99

- J7. How often did you watch video during the last month? .....

- Never. .... 1  
Everyday ..... 2  
Almost everyday ..... 3  
More than once a week ..... 4  
Less than once a week ..... 5

- J8. How often did you go to movie theater during the last month? ..

- Never ..... 1  
1-3 times ..... 2  
More than 3 times ..... 3

- J9. Have you ever heard of the internet? .....

- Yes ..... 1  
No ..... 2 ==> Skip to K1

- J10. Have you ever used the internet? .....

- Yes ..... 1  
No ..... 2 ==> Skip to K1

- J11. What do you use the internet for?

- Yes ..... 1  
No ..... 2

J12.1. Chat .....

J12.2. E-mail .....

J12.3. Finding information .....

J12.4. Playing games .....

J12.5. Other (Specify ..... )

- J12. How many hours did you use internet during last month?

## K. FUTURE

- K1. What are your aspirations for the future?

(Maximum two aspirations, in order of priority)

First .....

Second .....

- Employment career ..... 1  
Economic security/finance ..... 2  
Family and parenting ..... 3  
Overall happiness ..... 4  
Contribution to society/Viet Nam ..... 5  
Other (Specify ..... ) 6  
No aspiration/don't know ..... 9

- K2. Compare to your parents' life, do you think your life will be better, about the same or worse? .....

- Much better ..... 1  
Better ..... 2  
About the same ..... 3  
Worse ..... 4  
Much worse ..... 5  
Don't know ..... 9

- K3. Please mention two things, which you think the government should do to make the life of young people your age better  
(Maximum two things, in order of priority)

First:

Second:

- Increase education opportunities ..... 1  
Increase access to youth health services ..... 2  
Increase employment and work opportunities ..... 3  
Increase leisure opportunities and facilities ..... 4  
Policies/Laws for young people ..... 5  
Involvement and participation in society ..... 6  
Support family to provide better care for youth ..... 7  
Encourage youth involvement and participation in society ..... 8  
Other Specify( ..... ) 9

**Interviewer to thank respondent and introduce the self-completed to the respondent**

## SELF-COMPLETED

Circle the appropriate answers

1. Have you ever tried opium, marijuana, heroin or shaking drug? ☐  
 Yes ..... 1  
 No .. 2 ==> Move to question number 5
2. How old were you when you first tried the drug  
 (Don't remember then write 99) ..... ☐
3. Have you ever injected drug? ..... ☐  
 Yes ..... 1  
 No .. 2 ==> Move to question number 5
4. Have you ever shared needle with anyone when using drugs? ... ☐  
 Yes ..... 1  
 No ..... 2
5. Have you ever taken part in motobike racing? ..... ☐  
 Yes ..... 1  
 No ..... 2
6. Have you ever taken part in a group riot? ..... ☐  
 Yes ..... 1  
 No ..... 2
7. Have you ever hurt someone badly enough to require medical  
 treatment? ..... ☐  
 Yes ..... 1  
 No ..... 2
8. Have you ever carried a weapon? (not including as tools for guard,  
 livelihood ) ..... ☐  
 Yes ..... 1  
 No ..... 2
9. Have you ever been injured as a result of violence outside home? ☐  
 Yes ..... 1  
 No ..... 2
10. Have you ever been injured as a result of violence from a family  
 member ? ..... ☐  
 Yes ..... 1  
 No ..... 2
11. Have you ever felt sad about your life in general? ..... ☐  
 Yes ..... 1  
 No ..... 2
12. Have you ever felt so sad or helpless that you stopped doing your  
 usual activities? ..... ☐  
 Yes ..... 1  
 No ..... 2
13. Have you ever felt really hopeless about your future? ..... ☐  
 Yes ..... 1  
 No ..... 2
14. Have you ever tried to intentionally injure yourself ..... ☐  
 (not including tatoo)?  
 Yes ..... 1  
 No ..... 2
15. Have you ever thought of suicide? ..... ☐  
 Yes ..... 1  
 No .. 2 ==> Move to question number 17
16. Have you ever attempted suicide? ..... ☐  
 Yes ..... 1  
 No ..... 2
17. Are you married? ..... ☐

- Yes ..... 1  
 No .. 2 ==> Move to question number 20
18. Did your and your spouse have sex before you were married? .. ☐  
 Yes ..... 1  
 No ..... 2
  19. Did you have sex with anyone else than you spouse before your  
 marriage? ..... ☐  
 Yes ..... 1  
 No ..... 2

### MOVE TO QUESTION 25

20. Have you ever had a boyfriend or girlfriend? ..... ☐  
 Yes ..... 1  
 No .. 2 ==> Move to question number 24
21. Have you ever dated anyone? ..... ☐  
 Yes ..... 1  
 No ..... 2
22. Have you ever kissed your boyfriend or girlfriend? ..... ☐  
 Yes ..... 1  
 No ..... 2
23. Have you ever touched your boyfriend, girlfriend's private parts? ☐  
 Yes ..... 1  
 No ..... 2
24. Have you ever had sex with anyone? ..... ☐  
 Yes ..... 1  
 No .. 2 ==> Move to question number 45
25. How old were you when you first had sex? .....    
 (don't remember write 99)
26. What was the relationship between you and your partner? ..... ☐  
 (Circle the appropriate answer)  
 Spouse ..... 1  
 Your fiancé ..... 2  
 Boyfriend/girlfriend ..... 3  
 Friends ..... 4  
 Someone you know ..... 5  
 Stranger ..... 6  
 Sex worker ..... 7  
 Others (specify: \_\_\_\_\_) 8
27. How old was your partner at that time .....    
 (don't remember write 99)
28. Where did you have your first sex? ..... ☐  
 (Circle the appropriate answer)  
 At your house ..... 1  
 At your partner's house ..... 2  
 At someone else's house ..... 3  
 Hotel/inn ..... 4  
 Dormitory ..... 5  
 In the park ..... 6  
 Others (specify: \_\_\_\_\_) 7
29. Did you and/or your partner use any contraceptives during your first  
 sex? ..... ☐  
 Yes ..... 1  
 No .. 2 ==> Move to question number 31



Don't know don't remember 3 ==> Move to question number 32

30. What did you use ..... ☐ ☐
- (Circle the appropriate answer)
- IUD ..... 1
  - Oral pill ..... 2
  - Condom ..... 3
  - Injectable contraception ..... 4
  - Morning after pill (postinor) ..... 5
  - Female sterilization ..... 6
  - Male sterilization ..... 7
  - Withdrawal ..... 8
  - Ogino knauss ..... 9
  - Spermicide ..... 10
  - Others (specify: \_\_\_\_\_) 11

### MOVE TO QUESTION 32

31. Why didn't you use any Contraceptive for your first sex? ..... ☐
- (Circle the appropriate answer)
- I don't know how to use them ..... 1
  - I don't know how to find them ..... 2
  - I didn't intend to have sex at that time ..... 3
  - I didn't want to use them ..... 4
  - My partner didn't want to use them ..... 5
  - I felt embarrassment ..... 6
  - Other (specify: \_\_\_\_\_) 7
32. Did you continue to have sex after your first sex? ..... ☐
- Yes ..... 1
  - No ..... 2 ==> Move to question 34
33. Did you use any contraceptive in your last sex? ..... ☐
- Yes ..... 1
  - No ..... 2
34. Have you been forced to have sex with anyone? ..... ☐
- Yes ..... 1
  - No ..... 2 ==> Move to question 38
35. Did you know that person before? ..... ☐
- Yes ..... 1
  - No ..... 2
36. After being forced to have sex, did you tell anyone about it? ... ☐
- Yes ..... 1
  - No ..... 2
37. After being forced to have sex, did anyone comfort, soothe you? ☐
- Yes ..... 1
  - No ..... 2
38. Have you ever paid anyone to have sex with you? ..... ☐
- Yes ..... 1
  - No ..... 2
39. Have you ever been offered money to have sex with someone? ☐
- Yes ..... 1
  - No ..... 2
40. Have you ever had sex with commercial sex workers? ..... ☐
- Yes ..... 1
  - No ..... 2 ==> Move to question 43
41. Did you use condom in your last sex with commercial sex worker
- Yes ..... 1 ==> Move to question 43
  - No ..... 2
42. Why didn't you and your partner use condom? ..... ☐
- (Circle the appropriate answer)
- Didn't know where to buy ..... 1

- Didn't intend to have sex at that time ..... 2
  - Didn't want to use condom ..... 3
  - My partner didn't want to use ..... 4
  - I was too shy to buy condom ..... 5
  - Others (specify: \_\_\_\_\_) 6
43. How many sexual partners have you had during the last 12 twelve months. .... ☐
44. How many times did you have sex in the last month? ..... ☐
45. Bellow are some statements about sex workers, you may agree, disagree or be unsure ..... ☐
- 45.1. Comercial sex is immoral ..... ☐
- Agree ..... 1
  - Do not agree ..... 2
  - Not sure ..... 3
- 45.2. Comercial sex is bad but some have to do it because of their circumstances ..... ☐
- Agree ..... 1
  - Do not agree ..... 2
  - Not sure ..... 3
- 45.3. Commercial sex is bad or not, depending on each person's perception ..... ☐
- Agree ..... 1
  - Do not agree ..... 2
  - Not sure ..... 3
46. Bellow are statements about premarital sex, you may agree, disagree or don't know how to answer?
- (Circle the appropriate answer) ..... ☐
- 46.1. Premarital sex is acceptable if the two persons are willing to do it. ☐
- Agree ..... 1
  - Do not agree ..... 2
  - Not sure ..... 3
- 46.2. Premarital sex is acceptable if the two persons love each other ☐
- Agree ..... 1
  - Do not agree ..... 2
  - Not sure ..... 3
- 46.3. Premarital sex is acceptable if the two persons are about to get married soon ..... ☐
- Agree ..... 1
  - Do not agree ..... 2
  - Not sure ..... 3
- 46.4. Premarital sex is acceptable if the two persons are mature and know the consequences ..... ☐
- Agree ..... 1
  - Do not agree ..... 2
  - Not sure ..... 3
- 46.5. Premarital sex is acceptable if the woman can be prevented from pregnancy ..... ☐
- Agree ..... 1
  - Do not agree ..... 2
  - Not sure ..... 3

**Male respondent and female who has not had sexual intercourse finish the questionnaire here - thank you**

## THIS PART IS FOR WOMEN WHO HAVE HAD SEXUAL INTERCOURSE

47. Have you ever been pregnant? ..... ☐
- Yes ..... 1
- No ..... 2 ==> Finish the questionnaire
48. Have you ever had abortion? ..... ☐
- Yes ..... 1
- No ..... 2 ==> move to question 51
49. How many times did you have abortion? ..... ☐
- 50.1 Who decided your first abortion? ..... ☐
- (Circle the appropriate answer)
- Myself ..... 1
- My husband ..... 2
- My boyfriend ..... 3
- My parents ..... 4
- Others (specify: \_\_\_\_\_) 5
- 50.2 Where did you have it done? ..... ☐
- (Circle the appropriate answer)
- Commune health center ..... 1
- District health center/ hospital..... 2
- Private clinic ..... 3
- Other health facility..... 4
- Other (Specify \_\_\_\_\_) 5
- Don't know, don't remember ..... 9
51. Have you ever given birth? ..... ☐
- Yes ..... 1
- No ..... 2
52. About your first pregnancy, did you give birth, or have an abortion, or miscarry?. ..... ☐
- Give birth ..... 1
- Abort ..... 2
- Miscarry ..... 3
- Other (specify \_\_\_\_\_) 4

***Thank you and good health***